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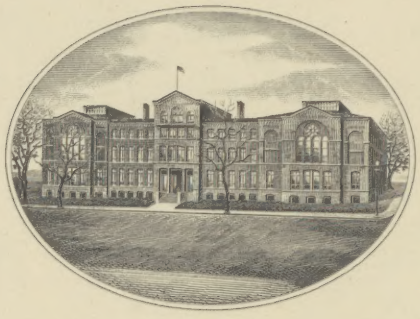

NINTH SERVICE COMMAND

Hand Write

RECONDITIONING CONFERENCE

HELD AT

MODESTO, CALIFORNIA

Recondit. Conf. (9. Serv. Com.)

June, 16-17 1944

ARMY SERVICE FORCES · WAR DEPARTMENT

RECONDITIONING PROGRAM*

I. Brigadier General J. M. Willis, Service Command Surgeon, HNSC

Presiding

Friday Morning
16 June 1944

II. WELCOME TO NINTH SERVICE COMMAND CONFERENCE
Major General David McCoach, Jr., Commanding General, NSC

III. WELCOME TO HAMMOND GENERAL HOSPITAL
Colonel L. R. Poust, M.C., Commanding Officer, Hammond General Hospital

IV. OBJECTIVES OF RECONDITIONING
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V. PLANNING THE PROGRAM FOR RECONDITIONING
Colonel Augustus Thorndike, M.C., Director, Reconditioning Division, Surgeon General's Office 7

VI. ADMINISTRATION OF RECONDITIONING PROGRAM IN RELATION TO PROFESSIONAL SERVICES.
Colonel Paul E. Keller, M.C., Chief, Professional Services, and Deputy Service Command Surgeon, HNSC 11

VII. PHYSICAL RECONDITIONING IN CONVALESCENT CLASSES III AND II
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VIII. EDUCATIONAL RECONDITIONING ACTIVITIES, CLASSES IV AND III
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IX. THE PSYCHIATRIC PATIENT IN THE RECONDITIONING PROGRAM
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X. DISCUSSION

LUNCHEON

Afternoon Session
16 June 1944

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Major George H. Ivins, Director, Morale Services Division, HNSC 36

XII. RECONDITIONING AS A SUPPLEMENT TO MEDICAL CARE
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XIII. COUNSELING, ADVISING, CLASSIFICATION, AND REASSIGNMENT IN RELATION TO RECONDITIONING
Major James R. Patrick, AGD, Deputy Director, Reconditioning Service, HNSC 40

ANNOUNCEMENTS: TOUR FOR OBSERVATION OF RECONDITIONING ACTIVITIES, HAMMOND GENERAL HOSPITAL

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* All sessions held in Auditorium, Hospital Recreation and Red Cross Building, unless otherwise announced.

- DEMONSTRATIONS OF SAMPLE ACTIVITIES, CLASS IV - III PATIENTS, HAMMOND GENERAL HOSPITAL

GROUP A	GROUP B	GROUP C
Ward A-8 (Class IV-III) (1) Physical Education (2) Education-Orientation	Ward B-7 (Class IV-III) (1) Physical Education (2) Education	Ward B-14 (Class IV-III) (1) Physical Education (2) Occupational Therapy
Ward B-8 (Class III) (1) Physical Education (2) Organization, HGH	Ward B-8 (Class III) (1) Physical Education (2) Organization, HGH	Ward B-8 (Class III (1) Physical Education (2) Organization, HGH
Ward D-8, 10 (Class III) (1) Occupational Therapy	Ward D-8, 10 (Class III) (1) Occupational Therapy	Ward D-8, 10 (Class III) (1) Occupational Therapy
Swimming Pool	Swimming Pool (1) Class II, Orthopedic (2) Class II, Non-swimmers (3) Class I, Life-saving Instruction	Swimming Pool

Retreat Ceremony
Headquarters, Hammond General Hospital

Dinner

Evening Session
16 June 1944
Colonel L. R. Poust, M.C., Commanding Officer, Hammond General Hospital, Presiding

XIV. RECONDITIONING PROGRAM, PSYCHIATRIC PATIENTS, HAMMOND GENERAL HOSPITAL
Lt Col M. Zeifert, M.C., Chief, Neuropsychiatric Service

XV. RECONDITIONING PROGRAM, GENERAL MEDICAL AND MALARIA WARDS, HAMMOND GENERAL HOSPITAL
Lt Col G. Cheney, M.C., Chief, Medical Service; Medical Director, Reconditioning Division

XVI. RECONDITIONING PROGRAM, SURGICAL AND ORTHOPEDIC SERVICE, HAMMOND GENERAL HOSPITAL
Lt Col Joseph R. Shaeffer, M.C., Chief Surgical Service

INSPECTION, HOSPITAL EXHIBITS, NINTH SERVICE COMMAND

1. Auditorium, Red Cross - A representative from visiting hospitals will be available near the particular exhibit to explain the program of the hospital concerned.

2. Reconditioning Division, B-8, Hammond General Hospital Exhibit

OFFICERS AND NURSES CLUB
Entertainment as guests of the Commanding Officer and staff, Hammond General Hospital

Saturday Morning
17 June 1944

Lt Col John J. Loutzenheiser, M.C., Director, Reconditioning Service, and Orthopedic Consultant, HNSC

Presiding

XVII. SPECIAL SERVICES IN RELATION TO RECONDITIONING
Captain P. N. Hogensen, AUS, Assistant to Director, Special Service Division, HNSC

XVIII. SUGGESTIONS ON "REFRESHER" MILITARY TRAINING IN ADVANCED RECONDITIONING SECTION
Lt Col. S. W. Williams, M.C., Military Training Division, HNSC

XIX. DIRECTING A RECONDITIONING PROGRAM IN A GENERAL HOSPITAL
Capt Thomas P. Barrett, M.C., Director, Reconditioning Program, Bushnell General Hospital

XX. OCCUPATIONAL THERAPY IN RECONDITIONING
Miss Huldah Ann Steinmesch, OTA, Reconditioning Service, HNSC

XXI. OPERATION OF A RECONDITIONING PROGRAM IN A GENERAL HOSPITAL
Capt James W. Layman, AGD, Director, Reconditioning Division, Hammond General Hospital

TOUR FOR OBSERVATION OF ACTIVITIES IN ADVANCED RECONDITIONING SECTION AREA

Group A	Group B	Group C
(1) Dayroom	(1) Headquarters	(1) Dispensary
(2) Headquarters	(2) Dispensary	(2) Dayroom
(3) Dispensary	(3) Dayroom	(3) Headquarters
(4) Physical Education (Class II - I)	(4) Physical Education (Class II - I)	(4) Physical Education (Class II - I)
(5) Drill (Class I)	(5) Drill (Class I)	(5) Drill (Class I)
(6) Weapons Care (Class II - I)	(6) Weapons Care (Class II - I)	(6) Weapons Care (Class II - I)

TOUR, TROPICAL DIVISION SECTION, MALARIA WARDS

LUNCHEON

Afternoon Session
17 June 1944

XXII. COLONEL J. I. BLAKENEY, Chief Chaplain, HNSC.

XXIII. GROUP CONFERENCES AND DISCUSSIONS
Major James R. Patrick, AGD, Deputy Director, Reconditioning Service, HNSC, Presiding.

Panel:
Brigadier General C. C. Hillman, Surgeon General's Office
Brigadier General J. M. Willis, Service Command Surgeon, HNSC
Colonel Augustus Thorndike, M.C., Surgeon General's Office
Colonel J. L. Blakeney, Chaplain's Corps, HNSC
Lt Col John J. Loutzenheiser, M.C., Director, Reconditioning Service, Orthopedic Consultant, HNSC
Lt Col S. W. Williams, M.C., Military Training Division, HNSC
Major Arthur A. Esslinger, AUS, Surgeon General's Office
Major Walter E. Barton, M.C., Surgeon General's Office
Major William S. Briscoe, AUS, Surgeon General's Office
Major George H. Ivins, Director, Morale Services Division, HNSC

XXIV. SUMMARY AND CLOSING OF CONFERENCE
Brigadier General John M. Willis, Service Command Surgeon, HNSC

APPENDIX
Delegates in Attendance

I. BRIGADIER GENERAL J. M. WILLIS
Service Command Surgeon, Ninth Service Command

Gentlemen, this conference has been called for the purpose of discussing the Reconditioning Program as we are required to carry it on in this Service Command. This phase of hospital work is becoming more and more important as the war progresses. I trust, though, that we will not let the tail wag the dog. We must realize that this is an adjunct to medical and surgical care and does not replace it. Always the pendulum swings to the extreme. I hope, however, that we have reached a mean and that we can carry on in a reasonable normal course. Let the Reconditioning Program assume the place it deserves.

The program has been in operation for a sufficient length of time to observe the advantages and disadvantages, the good points and the undesirable features. Some have discovered short cuts that will help others; some have discovered unneeded procedures. I think that by a discussion of all these points, and the features that we have observed in our various hospitals, we will derive mutual benefit from a conference of this nature.

It will be noticed that the schedule provides for ward demonstrations of reconditioning this afternoon. Tomorrow morning there will be a demonstration of Class I and Class II activities, and the afternoon will be devoted to individual problems and group conferences. It is believed that these ward demonstrations will be highly instructive as well as interesting. The time allotted in the afternoon of the second day should give you an opportunity to discuss individual problems with the various officers in charge. We are most fortunate this morning to have with us the Service Command Commander. He has given his full, hearty support to this program. I am very grateful to him for being here and it gives me a great deal of pleasure to introduce to you, Major General McCoach, Commanding General, Ninth Service Command.

II. MAJOR GENERAL DAVID McCOACH, JR.
Commanding General, Ninth Service Command

General Willis, General Hillman, distinguished guests, and officers of the Ninth Service Command. It is a pleasure to me, I assure you, to meet with you and to discuss this most important program. No one realizes more than I that this is a very technical subject on which I could not add much in a technical way, even if I so desired. However, in opening the conference, perhaps a few observations of the importance of the Reconditioning Program from the command point of view may be of interest, perhaps even of help. There are many reasons why from strictly a command point of view, the Reconditioning Program is of great importance. All of us have been plagued with the manpower situation for months, and there is no indication that there is going to be any let-up of that so, I think, from a purely--what you might call a selfish point of view--it is not, however, selfish that we must get every man back to duty or at least to related war work in the fullest sense in the least possible time. This is a sound basis for the Reconditioning Program.

We are all, of course, interested in the reduction of cost and we all know that one of the most expensive places to keep a man is in a hospital. So that furnished further emphasis for the necessary success of the Reconditioning Program. As to the importance of the Program, all we have to do is point out the interest manifested by the Commander In Chief, the President, the Secretary of War, the Commanding General, Army Service Forces, General Somerville, and all others concerned. I think with these few observations we can rest assured that the Reconditioning Program is of extreme importance to the War Department and a program that must be put across in the Ninth Service Command when it is among the first of the first priorities. The War Department has placed this program, very properly, in the hands of the Medical Department. But speaking as a layman, I do not believe it is solely a medical problem. It is a morale problem as well as a medical problem and for that reason I believe it is necessary

for our morale officers, special services officers, the chaplains, and even our personnel officers to be in on it and actively engaged in this program. It is a program which, if it is to be successful, has to be highly coordinated with all these activities.

The War Department, in establishing this program, does just that--establishes a program. It cannot and has not, so far as I know, gone into great detail as to the nature of the work to be done. That is up to the local medical officers, morale officers, chaplains, etc. The success of this program is not going to be dependent upon the broad outline of the instructions issued from Washington. It is going to be dependent upon the initiative and imagination of those in charge of the program locally. In this connection, I think it is well to point out that these exhibits around the room indicate, as General Willis has mentioned, that we have a good start. The invasion is now on and it may, perhaps, be only a matter of days or weeks before every hospital in the United States, perhaps will be filled with patients, so it is necessary that this program be carried out now. We have passed the planning stage; it is necessary that we get action and get it quickly if the program is to be successful. I have been very much impressed with the exhibits I have seen in this room and in the adjoining room. I feel that the Ninth Service Command has already got a good start. I believe that through this conference, with the help and assistance of General Hillman and the Surgeon General's Office, much will be gained and as a result of it, the Reconditioning Program will proceed in a very rapid and successful manner. I am very happy to be here with you and participate in this conference.

BRIGADIER GENERAL J. M. WILLIS: Thank you, General. The next feature of the program is our host--I would like to call on Colonel Poust. I think he has done a magnificent job in getting the program started as he has: Colonel Poust--

III COLONEL L. R. POUST MC
Commanding Officer
Hammond General Hospital

We are fortunate indeed that Hammond General Hospital is located centrally, hence its being selected for this conference of the Ninth Service Command. During the past many months we rarely have had any notable visitors; why, I do not know unless it is because of the existence of a false impression that it is unbelievably hot for a long time in this part of the Valley. However, I have spent two years here, and this is my third summer, and at no time during those two years has it really been uncomfortable. The nights are invariably cool and quite invigorating. The heat during the day time isn't bad, as there is so little humidity and a good breeze invariably prevails. I noted in the transcript of the meeting at the England General Hospital, Atlantic City, that the climate was referred to at length, and because of its splendid weather Atlantic City was considered an ideal place for reconditioning activities. The climate here in the North San Joaquin Valley is ideal for reconditioning activities. Outdoor activities can be participated in throughout the year. the rainfall of ten to eleven inches is scattered over three months--December, January and February--but rarely only would outside activities be interrupted. We have a very large fresh water plunge, which is quite popular during most of the year.

Here we have been carrying on reconditioning in some form or other for over a year. You will observe in our exhibit some photographs made April, a year ago, showing a large number of patients at work in the garden. As we cleared over $5,000 from the hospital garden in vegetables, it is suggestive that the patients really did work. We did not maintain records or have the various administrative details recorded as is now required, nor did we have the athletic or educational programs, now so prevalent. It was in truth a physical "build-up".

We have stressed occupational therapy here from the very beginning of this hospital, having first installed a shop in the closed psychotic

section where anyone interested in psychotic cases and occupational therapy can see what this activity has accomplished, both mentally and physically, for these patients. In addition to this one shop which was our first and activitated the first part of 1943, there are two other shops for general use.

Last year we housed the patients being reconditioned in separate wards, and it was not until January 2 of this year that we were able to move the Reconditioning Center to the T/O area, which, by the way, is ideal. We feel that the Reconditioning Program is productive of much good. As a result of their mental and physical activity the patients feel, eat, and sleep better, and return to a duty status in good general condition.

I haven't seen any figures or statistics concerning the following, so thought they might be interesting: We have found that approximately 90% of all patients CDD'd, except the psychotic cases, leave the hospital having jobs obtained through their own efforts. Furthermore, we have ascertained that 58 out of 64 of those not having jobs, obtained employment through the services of the United States Employment Commission here in Modesto, prior to CDD. I realize no one should experience difficulty in obtaining employment, but figures quoted merely emphasize the results obtained in the orientation program and the patients' attitude.

At the present time we have over two hundred and fifty in our Reconditioning Division, and this represents approximately one-fourth or twenty-five percent of our total patient census. In our program we use quite a number of officer patients and enlisted men in the reconditioning activities and they are doing perfectly splendid work. We are most fortunate in having a very energetic line officer and a medical officer, both patients, both with considerable recent combat service abroad, who are keenly interested in this program and have been associated with it for quite some time. In order to make the program successful, it is necessary, first of all, to convince your chiefs of services and sections that it is well worth while, that it will not interfere with the professional treatment, will benefit the patients, and they will be able to observe the progress each patient is making. Arousing the enthusiasm of these chiefs is one of the most important steps.

Some time ago, and continuously since, the Commanding General of the Ninth Service Command stressed the subject of food waste. We here at Hammond are very food conscious and endeavor to do everything possible to lower the amount of edible food waste. We request your support and cooperation along this line.

We are very happy that you are here as our guests and wish that you could remain with us for a longer time in order that you might see more in detail our varied activities. We have attempted to make available various accommodations for you. There will be some errors of omission and commission, for which we ask your kind consideration. Lastly, it is my most sincere wish that you will find this conference a most profitable one.

BRIGADIER GENERAL J. M. WILLIS: We have had reference made to the playground of America, Atlantic City, and that California has everything. We have a representative from the Surgeon General's Office who is the Chief of the Professional Services Division, and who has come to talk to the officers on the Reconditioning Program from that standpoint. It is my pleasure to introduce to you at this time General Hillman:

BRIGADIER GENERAL C. C. HILLMAN
Chief of Professional Services
Surgeon General's Office

Speaking in the broadest terms we may describe the Reconditioning Program as "planned convalescence." It is planned not only with a view to more rapid and complete recovery of the patient but also to the end that his time and thought may not be wholly lost to the military service while he is under medical care. It constitutes a very important part of that all inclusive Medical Department mission of conserving the fighting strength of the military forces.

For convenience we have seen fit to organize the Reconditioning Program into physical, mental, and educational activities. For the purpose of this discussion I would like to add an additional category, viz., "spiritual reconditioning." Of the details of physical, mental and educational reconditioning we shall hear more from other speakers on the program. I should like, however, to review briefly some of the features of each.

Physical reconditioning is clearly the easiest to plan and carry out. It is objective in its approach, its progress is susceptible of measurement, and its need is recognized by patient and doctor alike. It should be directed to the weakened member, if one exists, and to the body as a whole. The goal should be to begin early, follow through persistently, and approximate but never exceed the physiological tolerance of the affected part, or parts. In carrying out the physical reconditioning of patients in hospital wards, dependence must be placed wholly on the staff of the reconditioning service. Each ward officer should be imbued with the benefits to be attained through appropriate calisthenics and other ward exercises and he should cooperate in their employment as consistently as he does in other therapeutic procedures. Patient officers and enlisted men should be utilized whenever practicable in carrying out the program. Physical activity should be increased as rapidly as consistent with the patients' welfare and continued through the Advanced Reconditioning Section until as a Class I trainee he has developed the physical capacity to perform the ordinary duties of a soldier, or, if he is not qualified for general service, until he is fit to perform the duties that may reasonably be expected of him.

Mental reconditioning is a much more difficult phase of the program. This applies particularly to that large group of individuals suffering from those functional disorders that we classify as psychoneuroses. Since ward environment tends to aggravate the condition of these patients, it is especially important that they be removed as early as practicable from the hospital atmosphere. This does not apply, of course, to the homicidal, suicidal, disturbed or markedly depressed patient, or to one suffering from serious concomitant organic disease. For the others, however, early transfer to the Advanced Reconditioning Section is most important. Quite unlike other members of the Advanced Reconditioning Section, they will require active psychiatric treatment. It becomes essential, therefore, that the program of mental reconditioning be planned in cooperation with the psychiatrist and carried out with his active participation.

The educational program should be planned with purposes just as clearly defined as those for which physical reconditioning is carried on. For the man whose return to duty is contemplated, it should be designed to add to his store of basic military information. First aid, sanitation, personal hygiene, measures to take in the presence of various emergencies, map reading, care of equipment, and other subjects military in nature should form a base about which may be grouped various optional subjects to lend variety and interest. Whatever the subject, it should be presented only after adequate preparation on the part of the instructor. The enlisted man is not easily fooled and nothing will so effectively smother his interest as lectures, quizzes, or demonstrations given with inadequate preparation. If it is only a matter of filling the hours, he will much prefer to be left to his own choice. Close order drill should

be included in the daily program of those who are physically fit to take it, not only for its physical effect but for its disciplinary value as well.

The educational program should be considered in relationship to the critical shortage of manpower. Through it every opportunity should be taken to improve the soldier's mind to the end that upon completion of hospitalization he may be better prepared mentally for the military duties that lie ahead. A carefully directed educational schedule has the merit not only of making profitable use of time that otherwise would be lost to the military service but of overcoming boredom, improving morale and guiding the soldier's attention to the expectation of further useful service.

Still another matter of which we must take cognizance and probably the most important of all, is that of morale. In this connection, Colonel Hart, Surgeon of the Eighth Service Command, has coined a term which to me is very expressive. He speaks of "spiritual reconditioning." In it he includes with the planned work of the morale officer all those intangibles which together give the patient a will to get well, an active interest in the affairs of the day, and a desire to return to military duty, or, if incapacitated, to a useful position in civil life. Spiritual reconditioning should begin with one's entrance to hospital. From the day of admission to the time of discharge, the hospital atmosphere should stimulate in him the hope and the will for further accomplishment. Contacts with the professional staff, nurses and ward attendants, the mess, recreational activities and innumerable other factors will contribute to this composite effect. All hospital personnel should be kept keenly conscious of their duties in this regard. It may be said that their degree of success will be a fairly accurate measure of the general efficiency and morale of the hospital concerned.

Experience has shown that from 15 to 40 per cent of patients in fixed military hospitals are ambulatory and in no sense in need of ward medical care. Heretofore these cases have been held in wards, there having been no other place for them to remain until sufficiently recovered to resume their accustomed military duties. The Advanced Reconditioning Section now provides for this intermediate period, permitting the man to live in an environment and on a schedule approximating the normal soldier's routine. It frees him from the unfavorable psychological influence of intimate contact with other sick, give him varied and interested means of improving his physique, and at the same time provides a cushioning effect that is most helpful in the soldier's transition from pajamas and bathrobe to full military activity.

It has been found that transfer to the Advanced Reconditioning Section as soon as consistent with the medical condition contributes materially to improved morale. Recently a not-too-well educated soldier in trying to explain his preference for the Advanced Reconditioning Section hesitated a moment and said, "Well, you see, a fellow down here can sing whenever he wants to." That brings up a point - a good song leader is a valuable asset in the Reconditioning program. The spirit of music is contagious, and a song, classic or ribald according to their choice, will do much to lessen the fatigue of a cross-country hike. Full use should be made of the spirit of competition. Whether it be athletic sports, games, quizzes or discussions of current events, rivalry lends an interest that is not obtainable otherwise. While the whole Reconditioning Program must be approached with seriousness of purpose, in its execution it must be savored with features of interest to make it on the whole attractive rather than onerous.

Another objective of the Advanced Reconditioning Section is that it clears ward beds for more serious cases. With the increasing tempo of the war in Europe, it is possible that our ZI hospitals may soon be filled to capacity. By relieving wards of convalescent patients, we will enable professional and nursing staffs to concentrate more effectively on patients that need their closest attention.

At this point I should like to say a few words about the choice of an officer to conduct the reconditioning program of a hospital. We must keep in mind that we propose to require mental and physical activity that heretofore has not ordinarily been required of patients under our care. At every turn medical judgment is required to be assured that the patient is not required to exceed the limitations imposed by his illness or injury. It is necessary, therefore, that the program be directed and supervised by a medical officer. Success depends not only upon good medical judgment but also upon initiative, energy and enthusiasm, and finally upon his ability to sell the program to his assistants and the patients coming under his care. The choice of a Chief of Reconditioning Service should be made with these high requirements in mind.

In carrying out the program full use should be made of officer and enlisted patients. For officers who no longer require daily ward care the most effective reconditioning activity is their own participation in carrying out the program. It is only with their assistance that the program can be fully developed. They should be utilized to supervise ward calisthenics, and to assist in the educational and orientation activities of enlisted patients. Officer patients with special interests or with combat experience usually will engage eagerly in the program when it is once understood that their participation constitutes a valuable contribution thereto. The same holds with regard to noncommissioned officers and other enlisted men with special qualifications or battle experience. Their special capabilities should be discovered and utilized to the fullest extent. In this connection I should like to invite your attention to the remarks of Major General Ray E. Porter, Assistant Chief of Staff, G-3, at the Reconditioning Conference, Schick General Hospital, 21 March, this year. It is probable that you have received a copy of the minutes of that meeting.

Questions are frequently asked about the management of the C.D.D. case. He will be unable, of course, to complete the work required of the Class I trainee. Educational reconditioning in strictly military subjects will have slight appeal and correspondingly little value. But measures to improve his general physique and special exercises to correct any existing physical handicaps are indicated. It will be found that arts and crafts activities, occupational therapy, work projects and games best fulfill his needs. Every effort should be made to have him leave the service with a sense of pride in his accomplishments, the feeling that the Medical Department and the Army are interested in his future welfare, and that he still has an obligation and a capacity to continue in the war effort or fill some other worthwhile position in civil life.

According to War Department policy each incapacitated veteran should be restored as far as practicable to a normal state of health prior to discharge. It should be the practice, therefore, to routinely survey for dental defects the individual whose discharge on C.D.D. is contemplated and to make such repairs as are indicated.

Many of our hospitals have included in their programs various work projects under the title of occupational or possibly industrial therapy. They can be made very effective in mental as well as physical reconditioning. They are viewed with approval as long as assignment of each individual to such a project is made only with a clearly defined purpose. The relationship of the work to be done to the recovery of the patient should be clear to him. Above all, work projects should not be allowed to deteriorate into a source of cheap labor for hospitals.

It is desired to emphasize the thought that reconditioning programs cannot be rigidly standardized. After all, it is the principle upon which emphasis need be placed. Local facilities, available talent, and types of patients will so affect the program that at no two hospitals can it be exactly alike. It is obvious that the educational program for the battle wounded in a general hospital must be quite different from that provided for recently inducted men at the station or regional hospital of a replacement training center. Full use must be made of available civilian and military talent and of local environmental attractions to make programs varied and interesting.

The Surgeon General has had a number of requests from hospital commanders for authority to put their class 1 and 2 trainees into vocational training schools in the vicinity. In line with the War Department policy that reconditioning shall not be confused with vocational rehabilitation, these requests have not been approved. Many of you will recall the ineffective efforts at vocational training in our Army hospitals after the first world war. In order to carry on vocational training successfully, one would have to establish at each of our general hospitals a large school with all sorts of training courses and a large staff of instructors and other personnel. It is felt that such a program is not consistent with the best medical service in Army hospitals, and that unless and until the responsibility for vocational rehabilitation is placed upon the Medical Department rather than the Veterans Administration, we should not engage in activities directed primarily toward vocational training. I don't mean to say that educational work for prospective C.D.D. cases should not be something that might be useful in civil life, but if we begin to plan his reconditioning activities on the basis of civilian occupation, rather than on the basis of his medical need, the primary objective of the Reconditioning Program will not be achieved.

It is believed that well directed publicity has a very definite place in the reconditioning program. I think that all of us will agree that emphasis on reconditioning constitutes a notable advance in the management of patients in military hospitals. From that viewpoint alone, it is worthy of being told to the public. However, there is in addition a very distinct need for the patient, and for his family and friends, to fully understand the relationship of the reconditioning activity in which he is required to engage to his more rapid and complete recovery.

In this discussion I have deviated widely at times from the topic assigned. Returning therefore to the objectives of reconditioning, I should like to summarize them briefly in conclusion as follows:

To promote more rapid convalescence from mental and physical illness or injury,

To secure the greatest degree of recovery and restore the individual to duty mentally and physically fit to function effectively as a soldier,

To make full use of his period of convalescence for instruction with a view to increasing his military efficiency,

To stimulate the individual to renewed effort and give him a will to fight, or, if incapacitated for military service, to take his place in civil life and orient himself to the war effort, --and finally as a corollary attainment,

To promote the efficiency of Army hospitals by clearing ward beds and making them available for patients who require closer professional supervision.

BRIGADIER GENERAL J. M. WILLIS: I take great pleasure in introducing to you Colonel Thorndike.

LT. COLONEL AUGUSTUS THORNDIKE
Director, Reconditioning Division
Surgeon General's Office

In a little over four months assignment with the Reconditioning Division of the Surgeon General's Office, much planning and action by the Service Commands has produced what one may now consider a satisfactory program of reconditioning in ASF hospitals. To rate a program of this nature any higher at this stage would be an error. Individual hospitals vary greatly in the intensity of interest and alacrity of action with consequent varying results. Some have excellent programs, others have not! Some Service Commands are further ahead than others. One might say that excellent ratings for individual hospitals are spotty. In visiting your program in this Ninth Service Command one may note a great interest and the application of ingenuity to the solution of personnel and other problems.

A relatively new field has been entered by the Army in including as part of hospital care the physical and educational reconditioning of the patient. Muchhas been said in previous conferences that the critical manpower situation has forced this program on the Medical Department. There is no question in our minds that soldiers in the recent past have been perhaps too frequently CDD'd and that many ambulatory patients have been retained in hospitals idling away their convalescence. Let us consider what existed for the convalescent ambulant patient one year ago! The Red Cross Recreation workers provided much in the way of recreational equipment, motion pictures, indoor games, and reading material. Much was brought to the patient to amuse him, yes, but this type of recreation produced for his benefit caused him little or no mental exertion. One might say his mind was on the receiving end, not on the end of active exertion or not producing by stimulating the use of his intellect. Shows and stage entertainment in like manner provided amusement in which the patient was on the receiving end. The libraries of our hospitals were well equipped but experience showed that the soldier patient's interest was not in the intellectual class of literature but in the light fiction, even the comic strips.

The same situation existed relative to the physical state of the ambulant convalescent soldier patient. There was much time for physical idleness. Actually the patients exercised at the level and intensity so low that I believe the metabolic rate might have been raised to a level twice the normal. The soldier in training operates on a metabolic rate eight times the normal for an eight hour day. One can readily determine such a difference causing an unfavorable comment to arise among unit commanders when patients discharged to duty returned to their organizations in such condition. The rate of non-effectives in field units was rising by such a procedure.

The Surgeon General was prompt to rectify this and upon assumption of office introduced Reconditioning of the Convalescent into the professional care of the patient in our military hospitals. Furthermore, he created a new division within the Professional Service of the SGO to direct an active and intensive program.

Within that year and particularly within the last four months, many preconceived plans have been put into action. There is neither time nor space to elaborate in detail but it may suffice if one touches upon some of the more recent developments. The program as now operating is well conceived, but will not operate correctly unless the Chiefs of the Reconditioning Services of all hospitals keep constantly alert to the necessity of maintaining a balance in the schedule between the physical, the educational and the occupational phases in each class of patient. It is too easy and too simple to set up one schedule and develop a fixed idea as to the only way to produce a program. These conferences have proven of value, mainly in providing an opportunity for commanding officers and reconditioning officers to see and hear how other hospitals are operating. The free exchange of thoughts and ideas is beneficial to each and all of us. The idea that the program should progress in intensity must be fostered. The classification of patients has been set up purely on a physical effort basis, and not only should the patient progress physically but likewise educationally (primarily orientation and general information) and occupationally through all classes. In Classes 2 and 1 he must progress rapidly in military education both physically and mentally.

There is no intention to talk at this group! This exposition will serve purely to inform the members of this Service Command conference what the Reconditioning Division in the SGO has found elsewhere to be practical of application for the production of results. There is an obligation that must be fulfilled, namely to reduce the non-effective rate in field units by this program. Hospital stay periods must be reduced, hospital readmission rates must be reduced and the soldiers must be returned to duty in prime physical and mental condition. You are all advised again of this primary mission of reconditioning. It is well to determine from time to time that this mission is actually being carried out. It will pay you not to develop work or occupational therapy in

Classes 2 and 1 to such a state that physical reconditioning is sacrificed. My staff has seen this happen in more than one of our hospitals. Carry out physical fitness tests to determine periodically that conditioning is progressing. The period of hospitalization will be shortened if early, well designed exercise is given the Class 4 patient. Muscular atrophy will be allayed and prevented if bed patients are conditioned physically within the limits of the ward officer's prescription. Not all hospitals have appreciated this as yet.

Suggested programs of all physical and educational reconditioning and occupational therapy will be available in the new Reconditioning Manual. This manual is to be in three parts; Part I, Educational Reconditioning, Part II, Physical Reconditioning, and Part III, Occupapational Therapy. Preliminary unillustrated mimeographed texts of Part I and Part II are being distributed to hospitals and Service Command Headquarters at this time. Part III is in preparation. This manual will clarify many points in the program for all units in the field and furthermore it will serve as a text in the five courses operating to qualify specialist personnel.

Courses in approved schools have been authorized to qualify specialist reconditioning personnel and occupational therapists as follows:

Physical Reconditioning Instructors, EM, SSN-283, Camp Grant, Illinois, ASFTC - 6 weeks.

Educational Reconditioning Instructors, EM, SSN-653, Lexington, Virginia, Special Services School - 4 weeks.

Physical Reconditioning Officers, SSN-5521, Lexington, Virginia, Special Services School - 4 weeks.

Educational Reconditioning Officers, SSN-5500, Lexington, Virginia, Special Services School - 4 weeks.

Occupational therapists will be recruited and sent for an emergency course of four months in recognized private schools at government expense and serve an eight months clinical apprenticeship in certain named general hospitals for qualifications as a civilian occupational therapist as SP5. The list of schools so designated is as follows:

Boston School of Occupational Therapy	Boston, Mass.
Philadelphia School of Occupational Therapy	Philadelphia, Pa.
University of Illinois	Chicago, Ill.
Milwaukee-Downer College	Milwaukee, Wis.
University of Southern California	Los Angeles, Calif.
Richmond Professional Institute	Richmond, Virginia.
Columbia University	New York, New York.
Ohio State University	Columbus, Ohio.

The shortage of qualified specialist personnel in all phases of reconditioning is well known to all. The solution is to select a full quota of carefully chosen personnel to be ordered to these schools. Where will you find them? The answer to this question lies in your Service Command Headquarters, in your own medical detachments and in the roster of those patients to be discharged from the hospital under WD Circular 164, 1944 as amended. Your attention is invited to the latter group inasmuch as one of our general hospitals in the Sixth Service Command has obtained eight combat wounded patients transferred to its medical detachment by having the patient initiate the request and forward it through channels to The Adjutant General. Combat duty personnel are most desirable in the Reconditioning Program. Select them, send them to school and qualify them for service as reconditioning specialists. Train more than are required for your own needs as requests for such personnel have already come from overseas theaters. In the near future only that personnel

which is fully qualified at authorized schools will be assigned to the Reconditioning Service.

The Reconditioning Service has been recognized in AR 40-590 now under revision. A new overall WD Circular is in preparation and when published will give War Department recognition to a program which has been operating largely under ASF and AAF directives. Planning the overall program has been a time consuming and difficult task; producing the manual and establishing the schools for qualifying personnel has been difficult. The hospital programs have developed, successful conferences have been held now in all but one service command and one might say that Reconditioning per se had been born and had budded to its present state. When it will burst into full bloom will depend upon the Service Command Reconditioning Director, the Hospital Commanding Officers and their Chiefs of Reconditioning Service. One urges you to qualify your personnel which, when returned to your hospitals, will cause the program to blosson in full maturity. This program has come a long way!

D-day has been accomplished. Stop and consider the significance of that day as it pertains to Reconditioning. Clear your beds of able bodied patients; recondition those patients for duty. Our country needs every salvagable soldier. Recondition those patients so that they are better soldiers!

Think of those soldiers, sailors and marines on the landing barges! Let us ask ourselves if we are doing our part; question ourselves as to whether we are doing it with mediocre or with superior effort. Only a superior effort in reconditioning can maintain the desired manpower for the Army.

ANNOUNCEMENT BY MAJOR JAMES R. PATRICK, AGD: You have in your hands a little memo put out this morning with tomorrow's panel discussion leaders noted on the second sheet. I wish you would please write down your questions. The program is rather full and we don't have too much time for discussion immediately following the paper. If you will write down your questions and leave them on the desk, we will pick them up and then at the panel discussion we can cover any of the problems which may arise during the whole program.

BRIGADIER GENERAL J. M. WILLIS: Our next speaker is one from our own Service Command. I take pleasure in introducing to you Colonel Paul E. Keller, MC, who is on duty in the Surgeon's Office, Ninth Service Command

VI. COLONEL PAUL E. KELLER
Chief, Professional Services, and Deputy Service Command Surgeon
Headquarters, Ninth Service Command

General McCoach, General Willis, General Hillman, Ladies and Gentlemen. As a preface, the very nature of reconditioning requires that the program be under the supervision of medical advisors. Its purpose is to further the convalescence of practically all classes of patients by speeding their recovery and ultimate discharge from hospitals. At the same time it should prepare them to step back into duty of the most rigorous type compatible with any permanent physical or mental residuals. In order that results of the actual medical treatment given may be enhanced by mental or physical conditioning, the amount of the latter which the patient can tolerate at a given time must be determined through the professional knowledge of the medical practitioner, gained in his experience in treating the human body.

It would be well to state at this point that medical officers must consider reconditioning as much a part of their medical practice as the employment of medicines and other established methods of therapeusis. While most of the activities in this program will be carried out by the physical education and mental personnel, the medical staff should not feel that they can delegate the responsibility for proper procedure to the instructional staff. When this attitude prevails, the result obtained may be the direct reverse of that which is desired. The very purpose of reconditioning renders it a part of the doctor's continuing responsibility to his patient. Those who formulated the directives for initiating the Reconditioning Program fully realized that at all times, medical supervision is imperative.

In the Classes IV and III, determination of the individual patient's capabilities for entering into the program presents fewer difficulties, for here he remains under the watchful eye of the medical staff and more closely that of his immediate ward officer. The amount of entertainment, physical exercises, education and occupational therapy to be given during these periods is coordinated with his day by day medical record. It is during these phases and particularly in the bed patient class that more harm than good can be done if the capacity of the individual to absorb is overtaxed because of disregard of the medical phase of his treatment. On the other hand, valuable assistance can be rendered the body's innate tendency toward overcoming its ills by careful planning in each instance what course to pursue in reconditioning in particular diseases, especially the acute illnesses. An example of this is an observation made in one army hospital, that hyperventilation of the lungs in pneumonia cases, through deep breathing, initiated when the patient has become afebrile, has resulted in x-ray clearing in 96 hours in 90% of a series of cases recently studied. While this is an isolated study, it may prove significant with respect to what can be done in reconditioning.

As you know, the classification of patients into groups IV, III, II and I for reconditioning is the policy of the Surgeon General. Further, it is the policy to regroup these four classes into two, namely, - patients resident in hospital wards, both bed and ambulant, and patients resident in barracks outside the hospital.

When the patient graduates from the hospital section to the reconditioning section and becomes a so-called convalescent resident in the barracks set aside, special consideration must be given to him from the viewpoint of the professional services. These individuals remain patients, yet they require no immediate ward or clinical care; especially is this true of the most physically fit. As a rule, general medical supervision alone is necessary to supervise properly their continued participation in the program.

If during this period, the patient becomes acutely ill or requires the service of a specialist, he should be returned to the hospital section or such special clinic as is required. Despite the statement that only general

medical supervision is necessary, this supervision is of importance because without it an individual might be placed in a situation which would require performance beyond his capacity at that stage of his convalescence. One must remember that the responsibility for these Class II and I groups still rests with the hospital and only after final discharge of patients in this category should medical supervision cease.

Many in this section are the counterparts of that group which, in civil life, would be discharged from civilian hospitals and returned to their homes for further recovery before returning to their jobs. Even in civil life, the physician must follow up his hospital medical care, by periodic observation and advice to his patient who has returned home. In the army, we know that discharge from hospital means most often return to full duty commensurate with the limitations of any permanent disability that might be present. Since unit commanders have a definite training and work program to complete, it is not possible for them to permit groups of men to lie around in barracks. Because of this, the Reconditioning Program, in having as its aim the return of men capable of performing useful work, will be of invaluable assistance in carrying out the mission of the medical department.

Becoming more specific as to the relationship of the professional services in this program, one must remember that the program must fit the patient. Since the care of the patients in advanced reconditioning centers consists in putting them through various degrees of educational information, physical exercises, military refresher training and occupational activities and the locale being apart from the hospital section, direct supervision from a medical standpoint is no longer possible by the ward officer. This supervision must pass to the Medical Director of the Reconditioning Program. This officer checks the training and exercises given under the various instructor personnel in order that normal recovery may be encouraged and not hindered. For this check, necessary clinical and educational records for every man must be on file in the section. These records will serve as a guide in reconditioning and should include a summary of diagnosis and recommendations of the ward staff.

Thus, it is seen that the judgments of the professional staff become the guiding principles for the training program even though the supervision is not directly under the original ward officer.

The assumption underlying the Reconditioning Program is that by keeping men busy in wholesome, useful activities and in acquiring information regarding the affairs of the world, and in obtaining the restoration of precision in skills, therapeutic results and final recovery are hastened. The medical staff of the Reconditioning Section must evaluate continually, the physical and mental status of each patient while undergoing this training. While the operation of the program and the nature of the activities may be changed in this advanced section, still the professional services are responsible for determination of guiding principles and policies.

Further, some specific consideration must be given to certain types of cases. Patients with fractures and grafts for example may need repeated x-rays. Joint range of motion, muscle atrophy, deformities arising after operations must be investigated and surveys for dental care frequently made.

Convalescents are to be organized in sections, platoons and companies. It may be well to have convalescents grouped according to their medical history so that physical and military exercises may be given to fit each man's condition.

The commanding officer must not overlook the need for using specially trained officers and non-commissioned officers in all phases of instruction. This instruction may be more than remedial, for, while the patient is learning something for therapeutic purposes, he may likewise be learning something useful for reassignment or else is being exercised for restoration of functions once possessed but now somewhat lessened due to his battle wound or illness. While in this stage of recovery and training, each person should be seen individually at relatively frequent intervals in order that the activities pursued shall fulfill the purposes for which they were undertaken.

While convalescents should not be encouraged to report at sick call, they should be allowed to report to the dispensary or clinic if a condition requiring close medical attention should develop.

Some medical officers have remarked that patients admitted into convalescent centers are not a cross section of the Army; that to begin with they were problem cases. If this is true, and they were problems from a personality or ability viewpoint, they failed at some time in making adjustment to battle conditions and became the wounded. This matter has not yet been determined.

If patients are grouped for reconditioning on the basis of their medical history, there appear to be some medical cases that experience throws doubt upon as to whether or not they can profit from training in convalescent centers. The best summary of cases representing this viewpoint was given by Major Richard W. Britt, M.C., Chief of Professional Services, Convalescent Facility, England General Hospital, Atlantic City, New Jersey, and quotation is made as follows from the Proceedings of the Reconditioning Conference held 25-26 April 1944, at that hospital. These quotations are given here merely to cause us to be aware of different viewpoints:

"1. Acute arthritics become aggravated unless all inflammatory process has long been quiescent. The suggestion is offered that they be returned to duty after an adequate group III program or the beginners group II activities.

"2. The long-standing traumatic arthritic is often aggravated by the activities of the advanced groups and might well be returned to a limited form of duty after an adequate III program.

"3. Congenital deformities cannot be expected to improve in a 4 to 6 week program. We confess that we have had very little or no success in reconditioning those who are admitted to the hospital for pes planus.

"4. Cases of chronic osteomyelitis with draining sinuses have no place in the group I and II program.

"5. Nearly all ununited fractures must be transferred to the Orthopedic Service.

"6. Peptic ulcers, unless symptom-free and on a regular diet, rarely advance."

In the same paper Major Britt reported definitely good results in the following cases:

"1. Post-operative abdominal surgery.

"2. Post-infectious asthenia following pneumonia, malaria, meningitis and other debilitating diseases.

"3. Orthopedic cases who have developed atrophy and loss of function following the application of a cast.

"4. Quadriceps atrophy following successful operative procedures on the knee."

"5. Fibrous ankylosis of a joint.

In concluding, I would like to make a short comment on one interesting point. The claim has been made in the smaller hospitals that the initiation and subsequent carrying out of a reconditioning program are beset with many difficulties. These claims are not entirely without grounds, not the least of which are the added duties imposed upon the numerically small personnel, the shorter length of stay in hospital due to the type of diseases and injuries treated, and the lack of funds and equipment to set up a program of sufficient proportions to stimulate the interest of the doctors and patients.

Having been a smaller hospital commander I feel that in part we cannot ignore these claims, but at the same time should continue to urge that directives be followed. These probably cannot be carried out to the letter, particularly in the Class II and I groups, but much can be done. Shortage of hospital personnel can be compensated partly by use of patients in such activities as ward work, cleaning of the inside of buildings and corridors and for outside work, care of the hospital grounds, gardening and the like.

BRIGADIER GENERAL J. M. WILLIS: Next on our program is a talk by Major Arthur A. Esslinger, of the Surgeon General's Office.

VII. MAJOR ARTHUR A. ESSLINGER
Surgeon General's Office

While the physical reconditioning program is concerned with the attainment of all aspects of military fitness, its primary objective is the development of physical fitness. Since this objective is so important, it is essential at the outset to clarify what physical fitness is. Physical fitness is defined as "the nature and degree of adjustment in activities involving vigorous muscular effort". Its components are:

1. Freedom from defect or disease.

2. Strength. Every soldier needs enough strength to do easily the heaviest tasks that he may encounter in routine and emergency activities. The most important aspects of strength for soldiers are arm and shoulder girdle strength, leg strength and abdominal strength.

3. Endurance. Endurance is defined as the ability to carry on while others are carried out. Every soldier needs enough endurance to perform the longest continued exertion he is likely to face. We recognize two different kinds of endurance. The first is muscular endurance. This is the type which permits an individual to continue for a long period of time in arduous activities without undue fatigue. The second type of endurance is called "cardio-respiratory endurance", otherwise known as "wind". This endurance is required for long distance running.

4. The fourth component of physical fitness is agility. Agility is characterized by the ability to change direction and to change the position of the body in space with great rapidity. Agility is synonymous with quickness.

5. Coordination. By coordination is meant the ability to integrate all parts of the body toward a single end. It includes flexibility and suppleness.

These components, or aspects, of physical fitness are the immediate objectives of the physical reconditioning program. The problem is to what degree should each of the components be developed before men are returned to duty. If all individuals were required to attain a single standard of physical fitness, the problem would be simplified because all of these components are easily measured. However, it is obvious that the soldier who will return to duty in a limited service capacity will not need the strength, stamina, agility and coordination that the infantryman or paratrooper will. For this reason it is necessary to study each individual separately and to develop in him the level of physical condition which he will need to carry on his job when he returns to his organization.

In achieving the objectives of the physical reconditioning program, certain guiding principles should be observed. (1) All activities in the Reconditioning Program must have medical sanction and supervision. The entire physical reconditioning program is predicated upon the ward officer's approval of the activities administered to the patients. The ward officer's sympathetic understanding and cooperation, therefore, are absolutely essential for the success of the program.

For this reason all officers should be oriented as to the importance and objectives of the Reconditioning Program. In traveling from hospital to hospital one cannot help observing the differences in ward officers' attitudes toward the physical reconditioning program. Some are apparently uninterested or unsympathetic and they give little if any support to the physical training instructors. They don't encourage their patients to participate in the activities and they permit only very light exercises which have little physiological value. Other ward officers with the same type of patients permit much more vigorous activity and they constantly encourage their patients to participate energetically.

(2) The second principle is that the Reconditioning Program must be adapted to the disability and needs of each patient. As General Willis has said, reconditioning is an adjunct and we must not let the tail wag the dog. Care must be observed that no exercise aggravates an injury. The reconditioning activities must promote and not retard recovery. Within the limitations imposed by this principle, however, much can still be done to expedite recovery. Evidence is available that exercise can start much sooner and be considerably more strenuous than was believed desirable only several years ago. Further, in surgical cases, there are always parts of the body not associated with the region of disability which can be exercised to advantage. (3) Any physical reconditioning program, whether it be for convalescents or for normal individuals, should begin with light exercise and gradually and progressively increase in intensity and dosage. Unless the amount of activity administered to patients is known with a considerable degree of accuracy, too much or too little exercise is given with the resultant retardation of recovery. (4) The full cooperation of the patients must be enlisted. The Reconditioning Program will fail unless the desire to improve is instilled in all men. They must be convinced that their own interests are best served if they are to participate wholeheartedly in the activities. Better results are always obtained if the patients are led rather than driven.

There are two effective methods of securing the cooperation of a patient. One is to orient him in regard to the purposes and methods of the program. He should know why he is being asked to do the exercises. A recommended procedure to accomplish this objective is by means of a booklet such as that employed here at Hammond General Hospital. The other method is for the ward surgeon to encourage participation in the exercises. Patients look upon their doctors with the greatest respect and confidence and will do anything they suggest. (5) The "overload principle" should be applied. By "overload" it is not meant that the load breaks the body down but rather that the load is greater than that normally carried. The human organism adapts itself quickly to the demand made upon it. If we wish to maintain physical condition we must make a physical demand at least as great as we have been making. If we want to improve we must make a physical demand greater than we have been making. For example, a man whose arm is strong enough to handle a 40-pound dumbbell may exercise to excess with a 5 or 10 pound dumbbell with no appreciable increase in the strength of his arm. If, however, he were to exercise with a 40-pound dumbbell for a few days until he gained more strength, and then used a 45-pound and then a 50-pound dumbbell, his strength would increase very rapidly. There is a further aspect of the "overload principle" which is of importance. The nearer exercise approaches the limits of one's present ability, the greater the development. Recovery is expedited when patients are exercised close to their capacity. It must be remembered, however, that the amount of exercise which "overloads" a Class IV patient is very different from that which "overloads" a Class I patient.

CLASS IV PROGRAM

The chief purpose of the Class IV program is to prevent the patient from retrogressing physically. The prolonged recumbency is weakening and unless the patient receives adequate exercise he will deteriorate rapidly. Someone has said: "A ten-minute investment with Class IV patients will pay hours of dividends with Class I patients."

At present the physical reconditioning program for Class IV patients is the weakest part of the program. Many ward officers are extremely conservative in regard to exercising bed patients. Evidence is accumulating, however, that exercise can be started much sooner and be more strenuous than was believed desirable only several years ago. The study of Rusk and Ericksen at Jefferson Barracks has provided evidence of the value of early exercise for certain medical cases. Powers has recently reported data on surgical cases which might have implications for the physical reconditioning program. Five types of cases - herniaplasty, appendectomy, cholecystectomy, miscellaneous abdominal procedures and pelvic operations - were divided into two groups, a control group on which traditional convalescent procedures were followed, and an experimental group which performed early postoperative activity. The patients in the experimental group were confined to bed for an average of 1.4 days only; the control group for 11.7 days. The experimental group spent 11.8 days as ambulatory patients in the hospital; those who followed the traditional convalescence remained 15.1 days. The average period of convalescence for the early activity group was 6.4 weeks; that for the control group was 10.5 weeks. These figures indicate that, by the elimination of deconditioning secondary to a period of 10-15 days of recumbency after major surgery, the patient may return with comfort and safety to his usual occupation four weeks earlier than has been customary when the traditional postoperative regimen has been followed.

These data by Powers illustrate the importance of early exercise to avoid deconditioning. In fact, the patients in the experimental group did not remain recumbent long enough to get out of condition. It is my personal opinion that if Powers had used other exercises in addition to being up and around and walking, he would have obtained even better results.

It is recommended that Class IV and Class III patients be divided into sub-classes A, B, and C respectively. The C patient is the one in the poorest physical condition, the A patient is in the best physical condition. These sub-groups make a finer classification and make possible a better adjustment of physical activity. There is no necessity for each patient to pass through all six of these groups before being assigned to a Class II group.

A wide variety of activities is not available for Class IV patients. The best type of activity is bed calisthenics. There are many excellent calisthenic exercises for bed patients and in our manual we have recommended a set for patients in this category. All the Class IV patients perform the first ten exercises after which the IV C's drop out. After six more exercises the IV B's discontinue. The IV A's perform an additional seven exercises.

In addition to calisthenics we may use resistive exercises and spring exercisers. Both these activities offer greater resistance than calisthenics, and are better strength developing activities.

Bed calisthenics as they are usually administered are not sufficiently vigorous. In many cases they involve only a few repetitions of breathing, arm waving, and finger flexing and extending exercises. While such activities have some value from the psychological standpoint, they are of doubtful physical value. In many cases much more strenuous exercises could be given. This practice has been followed with marked success in certain Army hospitals.

Greater progress could be made by Class IV patients if they were motivated to exercise much more than the twenty or thirty minutes per day which are scheduled. Recently I saw a patient who had been incumbent for more than four months with a fractured femur. With the exception of the leg in traction he looked as well-developed and as physically fit as a college football player. By speaking to him I discovered that he went through the series of exercises taught him by the physical training instructor from six to eight times daily. He did the exercises vigorously and for many more repetitions because he wanted to get out of the hospital as quickly as possible and because he felt better as a result of the activity.

In Canada in some of the military hospitals the practice of teaching surgical cases before their operation the exercises they are to do after the operation is a routine procedure. There is little doubt that patients can start these exercises better after having practiced them once or twice. This practice seems to have much to recommend it.

CLASS III PROGRAM

Since a much wider variety of activities are available for Class III patients and because these individuals can take part in them much more vigorously, their participation in the physical activities must be carefully guided. The application of exercise to these patients must be gradual and progressive. Unless the dosage of activity is known with a considerable degree of accuracy, too much or too little exercise is administered with resultant retardation of recovery.

Since calisthenics is the mainstay of the Class III program, it is essential that the dosage be measured accurately. A method is available for doing this. To utilize this method, however, it is necessary to employ the same exercises over the period of time a patient is in a class or grouping. No one can measure the dosage of activity with accuracy when new exercises are utilized every day. When the same group of calisthenics are used for a period of time the amount of activity is easily measured by the use of the cumulative count. The cumulative count is a method of indicating the number of repetitions of an exercise on the fourth numeral of a four-count exercise. Thus: 1-2-3-1; 1-2-3-2; 1-2-3-3; 1-2-2-4; 1-2-3-5; etc. In the case of a two-count exercise, the cadence would be: 1 - 1; 1 - 2; 1 - 3; 1 - 4; 1 - 5; etc.

When employing the cumulative count all four-count exercises are repeated the same number of times. Twice this number of two-count exercises are utilized. Thus, the first day's dosage for Class IV patients will be termed "4 and 8" or "5 and 10". This means four repetitions of all four-count exercises and eight repetitions of all two-count exercises. After two or three days the number of repetitions may be raised to "5 and 10" or "6 and 12". Thus, the amount of activity can be steadily and progressively increased.

The cumulative count possesses additional advantages. Experience will indicate a reasonable starting dosage which can be utilized for all patients. At the present time this seems to be either "4 and 8" or "5 and 10". The cumulative count provides the reconditioning officer with a means of prescribing an exact dosage of exercise for any group, even when conducted by untrained personnel. This is particularly important when so much use must be made of ward masters and patients. Finally, the use of the cumulative count serves as a self-testing and motivating device. Patients want to know how much they are expected to perform and they are exceedingly interested in the amount of improvement they are making. For these reasons it is recommended that the cumulative count be employed for all calisthenic exercises.

The Class III calisthenics are similar to those for Class IV patients. They may be executed as bed exercises although they are more strenuous when performed from the standing position. If at all possible, these patients should be taken outdoors or to the gymnasium for their exercise.

In performing calisthenics, or any other physical activity for that matter, all convalescent patients should understand that when they encounter an exercise which aggravates their injury they have full permission to desist. In such cases it is better to provide a substitute exercise rather than to permit the patient to merely stand at ease. Not included in this category are those individuals who should be encouraged to exercise despite a certain amount of pain and discomfort.

Surgical cases may be given remedial calisthenics in addition to those just mentioned, which are general, total-body conditioners. The remedial exercises are designed to improve a specific weakness which the patient may have. They should be done in addition to the general exercises.

Resistance exercises are also recommended for Class III patients. They are able to do a wider variety of such exercises now, particularly of the type where they resist each other. This gives more dosage and is frequently preferred by the patient over the ordinary calisthenics.

Many activities with equipment and apparatus may be used for patients in this group. Rowing machines, medicine balls, and heavy punching bags provide strenuous exercise and are particularly valuable in strengthening the upper trunk muscles, wrists, shoulders and elbows. In addition, there are Indian clubs, shoulder wheels, wrist rollers, spring exercisers, bicycles, pulley weights, stall bars and many other pieces of apparatus which provide exercises for specific disabilities. Dumbbells and bar bells are excellent strength developers. Tumbling and apparatus activities are splendid from the standpoint of developing agility, flexibility, and coordination, as well as strength.

All of the above activities are ordinarily carried on in the gymnasium. A number of them may be conducted on the ward by bringing the equipment in a cart. The various activities are prescribed for the patients so that each man gets to do what is best for him.

Class III patients may play a variety of the milder sports and games. On the ward such games as dodge ball, quoits with rope rings, throwing darts, bowling at a target with a soft ball, putting a golf ball, rope spinning, and throwing the medicine ball around may be employed to advantage. When they can get outdoors or into the gymnasium, games of pepper ball, practicing forward passing, punting, volleyball, deck tennis, badminton doubles, shuffleboard, horseshoes, croquet, table tennis, fly casting, soft ball, and other activities may be utilized.

Where swimming facilities are available, swimming should be actively promoted. Not only is it an excellent exercise but it is also one of the most popular forms of recreation. In addition to the exercise obtained from swimming, water calisthenics can be performed in the shallow end of the pool.

CLASS II PROGRAM

Classes I and II are each usually divided into two sub-classes, A and B respectively. A plan which has been successfully followed is to keep those who graduate into Class II-B together in a platoon and carry them as a group through the successive stages II-A, 1-B and 1-A. This plan does not preclude certain trainees from progressing at a faster rate when indicated. A new group is started each Monday. Those who qualify for the II-B program during the week are kept in a separate X Platoon until the following Monday.

The Class II and I programs are usually carried on at an advanced reconditioning center or at least out of the hospital atmosphere. This practice has proven successful and it is recommended wherever possible. However, when trainees are sent to an advanced reconditioning center from a number of different hospitals, great care must be exercised in reconditioning them because they are likely to represent varying levels of physical condition. They should be screened carefully upon their arrival in order to classify them properly. The Class II-B program should start with light exercise and gradually and progressively become more intensive.

All the activities which were used for Class III trainees are appropriate for the Class II program. A different and more strenuous set of calisthenics has been recommended in our manual. These exercises can be readily adapted for the Class II B trainees by executing fewer repetitions and providing more rests between the exercises. Guerrilla exercises have been found to be excellent supplements to the calisthenics.

Much marching and running should be done because one of the greatest needs of the reconditioning trainee is to develop more cardio-respiratory endurance. Prolonged bed rest appears to affect wind more than strength. Running has always been considered the best all-around conditioning

activity and those trainees who are able to run should receive much alternate double timing and walking, wind sprints, and cross country running. Properly constructed and administered obstacle courses are of some value although there is little to be gained from them which cannot be obtained in safer activities.

There should be considerable emphasis upon sports and games. It is possible to arrange tournaments in various sports and this heightens the competitive spirit of the men. Sports and games are as valuable from the psychological reconditioning standpoint as from the physical. These activities provide one of the best means of restoring an aggressive, fighting spirit in many of the convalescents. Sports also have a value in encouraging many patients to extend themselves more than they would under other circumstances.

Another type of activity is what we speak of as "work therapy". This is simply various types of work that can be done about the hospital. It should be carefully supervised so that the men in reconditioning activities are not considered just a labor battalion. These activities should be carefully chosen to correct the disabilities of the individual man. A man should not be assigned to a job just to get work done, but because that particular job will help his disability. Work therapy is usually not as strenuous as other physical reconditioning activities and will retard recovery if utilized to too great an extent. We know from experience that civilians who were mechanics, carpenters, painters, and the like, are not in good condition when they enter the service. A study has shown that the hospitals who devoted the greatest amount of time to work therapy had the lowest level of general physical condition in their trainees.

CLASS I PROGRAM

The Class I program is very similar to that for Class II trainees except that it is more strenuous. Another set of calisthenics which is quite similar to those for Class II has been recommended in the manual. More repetitions of each exercise are to be executed and the rests between the exercises are virtually eliminated. These continuous calisthenics have been used very successfully with normal troops.

In addition to calisthenics, guerrilla exercises, grass drills, combative events, relays, tumbling, running, swimming and sports and games are employed. Considerable stress should be placed upon marching because each individual must be able to march fifteen miles with a full pack before he graduates from Class I.

The program in Class I should represent an intensification of the Class II program. It should not be necessary to keep trainees in Class I for a long period of time. We know from our experience in conditioning selectees that a combination of calisthenics, guerrilla exercises, grass drills, relays, combatives, and sports and games performed for two hours per day for a period of three weeks can improve the level of physical condition about fifty percent. With the amount of time available for Class I trainees, even better results should be obtained in our Reconditioning Program.

There is no set time to keep convalescents in any stage of the program. They should be pushed through as fast as is consistent with their welfare. One man may be reconditioned in several days and another in several months. The trainee should spend as much time in Class I as is required to condition him to the point where he can carry on his job satisfactorily when he returns to his organization. For many trainees this will mean a higher level of physical condition than they had when their disability was incurred because the level of condition of their organizations will have improved in the interim. It is imperative that careful judgment be exercised in regard to returning Class I trainees to duty because too many recurrences are an indictment to the Reconditioning Program. Not long ago G-3 was so concerned over the large incidence of recurrences that they considered taking over the job from the hospitals.

BRIGADIER GENERAL J. M. WILLIS: Colonel Loutzenheiser has an announcement to make.

LT COL LOUTZENHEISER: Tonight at 7:45 there will be another movie here in this building. The next speaker to be presented is Major William Briscoe of the Surgeon General's Office.

VIII. MAJOR WILLIAM S. BRISCOE
Surgeon General's Office

*IMPLEMENTING THE EDUCATIONAL RECONDITIONING PROGRAM

SECTION 1 - HOW TO LAUNCH THE PROGRAM

General McCoach, General Willis, and General Hillman: Perhaps the most perplexing job that faces the Educational Reconditioning Officer is that of deciding how to go about the implementation of a program of educational reconditioning. It is axiomatic to say that there will never be enough personnel and facilities to carry on a program which the Educational Reconditioning Officer may consider ideal. It will always be necessary to improvise.

The typical situation faced by the educational officer may be described as follows: The hospital in which he serves contains approximately 1,750 normal beds; there are about 1,500 patients, of whom 450 are Class IV, 800 of whom are Class III, that is to say are ambulatory patients, and from 150 to 200 are in the advanced reconditioning section, Class I and II patients. Facilities comprise a gymnasium, under construction and not ready for occupancy, the usual Red Cross facilities, including an auditorium which will seat about 200 to 250 men, and the library seating approximately 60. The Educational Reconditioning Officer finds that he has one assistant who is an enlisted man.

With these facilities and personnel, he is expected to carry on an educational reconditioning program which will provide activity for all patients approximately two hours a day. How will he go about this task? Obviously, being one person, he cannot hope to carry the program himself. It will be necessary for him to enlist aid and it will be required of him to discover facilities for carrying out his program.

At this point, it is well for him to reflect on certain fundamentals as a preliminary to the planning of the program. (1) He cannot carry the program by himself nor is he expected to do so. His job is primarily that of getting patients to do things for themselves. (2) He is not expected to run a school. His job is one of stimulating patients to undertake educational activities themselves which will not only be interesting to them but will prepare them eventually for resumption of military duty or to return to civilian life. Emphasis should be placed on the former. Educational reconditioning should not be conceived simply as education organized into courses. Formal instruction while a part of the Reconditioning Program, will be secondary in importance to the promotion of a variety of interesting educational activities with content selected so as to achieve the mission of educational reconditioning namely to get men back to duty, but with such content presented in an informal interesting manner. A tip may be taken from the best modern advertising. This is not to neglect those patients who may be interested in correspondence courses and class work. While United States Armed Forces Institute Correspondence courses and classes in subjects for which self-teaching texts are available may be established, extension courses from nearby universities and schools may be offered. It is to be remembered that such activities will suffice for a relatively small percent of patients. From 70% to 80% will need to be provided for in other ways.

A review of suggestions on methods which will be found in this manual will be important for the Educational Reconditioning Officer. If he reminds himself that for the most part education will have to be present in short interesting units as educational recreation, he will have determined one further point of reference in the plotting of his course of action.

*Not read in full; summarized by Major Briscoe.

Still another point which may be useful is that he should not attempt to begin the entire program all at once, and have it said of him as it was of the Missourian on whose tombstone it was written: "Here lies John Paxton. He was energetic but he stirred up more snakes than he could kill." The program should be developed step by step as the facilities become available and group leaders and teachers are discovered and trained.

With the aforementioned cautions in mind, the Educational Reconditioning Officer will proceed approximately as is outlined hereafter.

1. The Educational Reconditioning Officer should design an educational interest questionnaire for gathering information regarding patient's interests, backgrounds, previous education, military experiences, special talents and abilities, and any other facts that may be pertinent for the development of the educational program. In the manual, "Off-Duty Education for Soldiers", (prepared for Orientation Officers Course, School for Special and Morale Services, Lexington, Virginia, 1944) which has been furnished each Educational Reconditioning Officer, is to be found a sample of such a questionnaire.

2. After the educational interest questionnaire has been prepared and before it is distributed to patients, the Educational Reconditioning Officer should plan a survey of the patients. Such a survey, while gathering data concerning the patients' educational interests, should at the same time apprise them of educational opportunities available. A listing of subjects and activities such as those contained in the United States Armed Forces Institute catalogs and in War Department Pamphlet 20-4, together with such educational activities as may be possible of provision through local sources will be advisable. In addition to discovering interests the gathering of information regarding patients should include discovery of those persons who can teach, speak, or in other ways aid in the program. Such survey should not be merely pencil and paper questionnaire. Personal contacts should also be made. The Red Cross Gray Ladies will be helpful in any such survey. However, any volunteers who may assist should be thoroughly indoctrinated as to the aims of the Reconditioning Program and carefully instructed concerning the objectives and techniques of the educational interests survey before being expected to participate. Following the survey, the interests of the patients as expressed on the questionnaire and as gathered from personal interviews should be studied and a few subjects in which greatest interest has been shown be selected.

3. After discovering educational interests of patients and after deciding on a list of educational activities to be offered, the Educational Reconditioning Officer should then undertake to recruit officers and enlisted men from among the patients who may be able to teach such subjects or who may be qualified to act as leaders of groups of patients. The group study method will be found effective with adults. Such groups are headed by a leader who conducts the class or group as a seminar. (See chapter on Methods - Seminars). The Educational Reconditioning Officer should not overlook the fact that there may be civilians in the local community who are qualified and willing to assist with the program. Generally colleges, universities and schools in the vicinity can be counted upon to supply teachers without cost.

4. Simultaneously with the surveys mentioned above, there should be a study made of the hospital facilities to discover places in which classes may be held. At the same time, the regulations of the hospital program of organization should be studied to determine the time of day most appropriate for educational activities.

The following steps are suggested in accomplishing these purposes:

a. Inspect the entire hospital plant making notes of rooms and other spaces suitable for holding educational activities. List and describe such spaces giving area, lighting, seating, heating arrangements and other factors pertinent to their use in the educational program. Assemble and study the data collected and on the basis of this, select the spaces which seem suitable and list these on a chart showing the hours and days when such spaces will be available.

b. From a study of the hospital regulations and based on personal observation as to hospital programs, draw up master program charts for each class of patients, IV, III, II and I. Indicate the times of day various activities occur, such as physiotherapy, occupational therapy, ward inspecting, and visitations of the ward medical officer, required rest periods, and other required activities in which patient must participate.

c. Combine the information gathered under (a) and (b) above. This may be done by drawing up a program chart showing the time and places educational activities may be held. Such a chart will indicate the possibilities for organized classes and groups of educational activities.

d. The task now remains of discovering group leaders and of organizing classes. It is advisable to hold personal interviews with patients whose questionnaires indicate they might be qualified to teach or to act as group leaders and whose medical records indicate they may be in the hospital for a considerable time and yet whose physical condition will permit such activity. A study of the librarian's records will also reveal patients with active intellectual interests. From such men a group may be selected to act as a committee of patients for the purpose of assisting in the planning and the direction of an educational reconditioning program. A number of meetings held with such patients prior to the launching of a program for the purpose of considering what educational activities should be undertaken, will be found to be well worth the time spent. Such a series of meetings will not only serve to indoctrinate group leaders and teachers with the aims of educational reconditioning, but will result in a more realistic program - one geared closer to the interests and needs of the patients. If those patients whose injuries or illnesses may require long periods of ambulatory convalescence and who are intellectually inclined can be interested in participating, they will constitute a committee of sufficient permanence to insure continuity of effort and it will not be difficult to develop an educational reconditioning program planned and directed by the patients themselves.

One of the important considerations for the Educational Reconditioning Officer will be to insure that there will be a time on the ward sufficiently free from noise and confusion permitting study and group work. A number of hospitals have found it advisable to assign officer patients to wards for one or more hours a day for the purpose of maintaining a study or library atmosphere during the educational hour. Ambulatory patients can go to study or group meeting centers. One hospital has developed four such centers and rotates groups of ambulatory, Class III patients, from center to center on a four-hour schedule. This hospital divides patients into four groups as follows: orthopedic, general surgical, neuropsychiatric, and medical cases. Four major activities as follows have been developed: Red Cross activities, educational and Special Services activities, physical training activities, and occupational therapy activities including work projects. Among the advantages claimed for this plan is that it

makes for a well-balanced program and gives everyone a definite part in it. Red Cross director, Special Services director, the Educational Reconditioning Officer, the Orientation Officer, the Physical Training Officer, and the occupational therapist each finds his proper place in such a program.

After the activities to be carried on have been determined, leaders discovered and indoctrinated, and places for carrying out activities found, it will be well to begin by selecting three points of the program for attack simultaneously; first, individual study through United States Armed Forces Institute texts and correspondence courses, and in other ways suggested later in this manual; second, educational activities which are recreational in nature with high interest appeal, but with content selected for its importance in terms of the mission, sometimes called "package education", such as popular lectures, popular science demonstrations, educational quizzes, current news reports, specific military problems and the like; third, meetings or classes required of everyone capable of attending them as orientation classes and weekly news reviews.

If a public address system is available, a fourth area might be attacked. By means of a public address system news and other educational programs can be presented in such interesting style as to intrigue most patients. Radio programs may also be selected for listening from those listed in Federal Radio Education Committee bulletins which are distributed to hospitals monthly. These may be broadcast throughout the wards if necessary equipment is available. If not, radios may be provided for wards and patients may be encouraged to listen to various programs of educational nature.

If at the start, the educational reconditioning program be planned as outlined above and attack be made in the three or four areas as indicated, it will not be difficult to expand these beginnings into a broader front according to plan as patient assistants are found and trained and facilities are forthcoming. New ideas will also be discovered as progress is made which can be incorporated in the program. If provision is made for placing upon the patients themselves as much responsibility as possible for planning and executing the educational reconditioning program, the program will grow beyond expectations--certainly far beyond what would be possible if the Educational Reconditioning Officer were to undertake to run the program all by himself.

What has been said above might be translated into a specific plan of procedure in installing the program. For Group III patients, for example, the Educational Reconditioning Officer might list the possibilities as he sees them, as follows:

a. Objective: Two hours of educational reconditioning activities daily between breakfast and supper. One hour after supper elective educational activities.

b. Plan.

(1) One hour daily of large group activity for six days a week.

First day - Assembly conducted by the patients.

Second day - Film, GI or other.

Third day - Lecture, outside speaker or outside program. Educational, Recreational.

Fourth day - Weekly news review, home front problems.

Fifth day - Orientation hour. Discussion of the progress of the war.

Sixth day - Consideration of some military subject.

(2) One hour daily of small group and individual educational activity.

First day -	Required activity:	or	Elective classes:
	Library		Talks
	Reading		Educational recreation subjects
	Individual study		Shop activities
Second day -	Military class.		
Third day -	Required activity:	or	Elective classes:
	Reading		Talks on educational recreation subjects
	Individual study		Shop activities
Fourth day -	Military class.		
Fifth day -	Discussion group.		
Sixth day -	Required activity:	or	Elective classes:
	Reading		Talks on educational recreation subjects
	Individual study		Shop activities

(3) Educational hours will be scheduled following a period of physical activity.

(4) The one hour of large group activity daily will be started with one hour of GI movies, and one other hour per week of one of the other activities listed above, whichever may appear to be most interesting to patients. Additional hours per week will be added as programs are developed.

(5) The one hour of daily small group and individual activities will be begun by organizing wards so as to preserve a library atmosphere, that is to say, a minimum of moving about and a maximum of quiet. Patients on wards will be asked to assume responsibility for maintaining proper study atmosphere in their wards after the program has been explained to them, or, officer patients will be assigned to this task. Next, each man will be asked to undertake some activity either of an individual nature as indicated or to take an elective class as these are progressively opened. One hour per week will be devoted to some military subject, followed by a second hour when the first hour gets to going well. One hour of small group discussion will be developed on each ward, either tied in with the large group orientation program or on some subject interesting to the men and pertinent to the mission of educational reconditioning.

(6) After supper educational activities will be developed on a voluntary basis.

c. Initiation of the plan will proceed as follows:

(1) A survey will be made of patient's needs and interests.

(2) Those patients who have qualifications for leadership, who will be in hospital a considerable time and whose physical condition permits, will be selected to assist with the program.

(3) Such patients will be formed into a committee to help plan and carry out a program. Their work will be recognized as important and they will be made to see its importance through proper orientation and through the recognition of it by the commanding officer.

(4) In a meeting called by the commanding officer, at which the committee of patients who have been selected will be present, the hospital staff will be informed of the plan and their cooperation and assistance requested.

(5) The program will be launched with patients at a meeting at which the commanding officer will preside. After a brief but thorough explanation of the reasons for the program, the first patient assembly which will be the beginning of such, will be held. Careful planning should have made this first meeting interesting and stimulating. Additional large group activities will be added progressively until a full week daily program is in operation.

(6) The next step will be to require each man to plan his first week's activity for occupying his time during the individual study hour and to file a copy of such plan with the ward chairman or patient officers in charge of the ward. The first week's plan will require each individual to plan to occupy his time with self-directed activities.

(7) The second week the first organized classes will begin. Enrollment will be selective.

(8) After the program is started the Red Cross will be asked to assist in carrying on educational recreational projects and activities for patients who prefer them.

(9) Required military studies will be introduced as soon as three weeks of such studies have been prepared, are judged to be interesting by the patient committee, and suitable instructors found. These should be in operation by the third week.

(10) Patients who assume responsibility in the program for important and continuing assignments will be asked to recommend their successors and to have an understudy for their jobs.

It will be recognized that the approach suggested above is but one way of launching a program. There are other ways which would be equally effective. The point is to have some carefully thought out plan of beginning.

SECTION 2 - IDEAS FOR ACTIVITIES

The following suggestions are offered for the purpose of stimulating the imagination of the Educational Reconditioning Officer. It is not intended that all of them will be carried out.

1. Through means of the hospital newspaper, traveling library, exhibits, and personal contacts, inform patients concerning United States Armed Forces Institute correspondence courses available to them. Make it possible for such patients to look over United States Armed Forces Institute catalogues and "THE LIST OF COURSES OFFERED BY COOPERATING COLLEGES AND UNIVERSITIES THROUGH UNITED STATES ARMED FORCES INSTITUTE, WAR DEPARTMENT PAMPHLET NO. 20-4, 14 January 1944." Allow the patients to examine copies of United States Armed Forces Institute Self-Teaching Texts.

2. Study the librarian's record of patients who are reading library books and select the names of those men who seem to be interested in serious subjects. Gather these men together into a discussion group. Assume only so much leadership as is necessary to get the group organized and turn the project over to the group itself.

3. Encourage the librarian to form a library committee of patients. Let such committee assist in ordering books and in making annotated bibliographies and in preparing annotation for the cover pages of books. Such annotation in cover of pages might read as follows: "If you have only a few minutes to spend with this book, it is suggested that you read pages ____ to ____."

4. Ask the librarian to prepare exhibits of books on orientation which may go with the traveling library through the wards.

5. Encourage book review meetings and arrange the presentation of book reviews over the public address system. Be sure that those who review such books are able to do so entertainingly.

6. Prepare daily news broadcasts to be given over the public address system or to be posted upon strategically placed bulletin boards or to appear in daily news releases in mimeographed or printed form.

7. Encourage radio listening. For this purpose, refer to the Columbia Broadcasting System "School of the Air" and to the "Federal Radio Education Committee Radio Programs" issued monthly.

8. Show GI movies on the wards and in the recreation halls.

9. Collect packages of GI movies and edit them for use in connection with the education program.

10. Contact local film depositories and the State University of the State in which the hospital is located to determine what educational films are available for use in the educational reconditioning program.

11. Inquire from local educational institutions, including schools, colleges and universities, what extension courses may be available for patients in hospitals.

12. Contact the local luncheon clubs, superintendents of schools, and other persons who might know of skilled lecturers who may be available for talks on interesting subjects.

13. Invite a committee composed of representatives of local or state service clubs, such as Kiwanis, Rotary, etc. to assist in planning a series of interesting meetings.

14. Encourage the organization of clubs within the hospital, such as the lawyers club, automotive workers club, etc. Men enjoy discussing their various civilian occupations.

15. Organize short unit courses in subjects interesting to men, such as how to write a love letter, now to hunt a job, etc.

16. Undertake the review of Army subjects previously learned.

17. Study other branches of the service, and have men from other branches of the service lecture upon topics relating to the functions of their branches, such as combat principles for infantry, tanks, aircraft, etc. In presenting such subjects, make use of training films, lectures, discussions, graphic portfolios, etc.

18. Prepare scrapbooks selecting the comments of news commentators, as for example, "What Walter Lipman Thinks".

19. Prepare scrapbooks containing geographical notes as, "Islands you have never heard of", "Queer peoples from far places", etc.

20. Prepare scrapbooks concerning persons of importance in the news, biographical in nature.

21. Encourage writing of personal comments and essays to be published in a book of collections kept in the library entitled "What the GI Thinks".

22. Establish a newspaper reading class. Very few people know how to read the newspaper because not many of us have any newspaper reading background. There are texts which are available on newspaper reading. These can be located by consulting the United States Catalogue in any good library. Also, it would be possible through reading the newspaper over the broadcasting system and through comments to build up a background of reading interests by following day by day currents of events. Not the word "currents" is plural. This implies that certain major topics or currents of events will be followed daily.

23. Contact industrial firms for the purpose of securing lecturers and demonstrators of modern appliances such as the telephone, refrigeration, electrical equipment and the like.

24. Develop a series of educational recreational projects such as the following:

25. Provide educational games.

26. Arrange demonstrated lectures in science.

27. Teach tricks and short cuts in mathematics.

28. Have a Believe It or Not hour of an educational nature.

29. Have an hour on the debunking of commonly held erroneous ideas.

30. Have some educational quiz programs.

31. Arrange a spelling contest.

32. Have a grammatical usage contest.

33. Teach the playing of simple musical instruments.

34. Teach music appreciation through listening to music so as to determine story in music, rhythm in music, melody in music, instruments of the orchestra and in music. The Red Cross can help effectively here.

35. Invite various speakers to discuss and to describe their various professions. Don't forget the medical officers.

36. Invite members of the medical staff to discuss Facts and Fancies in Diet; Superstitions in Self-medication.

37. Schedule a series of lectures on discussions on little known facts about our government such as activities of "The Rural Electrification Administration".

38. Form a patients Chamber of Commerce for each state and encourage the man to advertise the advantages of being there. This should cause a lot of interest and perhaps also create some humor.

39. Get a committee of men to study the local history of the area in which the hospital is located.

40. Encourage men to write their own autobiographies, humorous if possible.

41. Organize a liar's club and start a contest.

42. Teach art, cartooning, pencil drawing and painting, and hold an exhibit.

43. Start a group in dramatic reading of plays for their own entertainment and also for the entertainment of other patients.

44. Start a class in photography.

45. Start a group in writing creative music.

46. Start a class in writing of poetry.

47. Begin a practical public speaking class and hold a mock political convention with speeches.

48. Start a class in story writing.

49. Introduce knitting, rug hooking, etc.

50. Organize a class in clay modeling and cartooning in clay.

51. Start a group in the writing of jokes and anecdotes.

52. Ask men to prepare papers or discussions on oddities or little-known items about various trades, professions and the like.

53. Hold an assembly for presentation of patient productions suggested above.

54. Review basic learning skills. Prepare tests with catchy titles: "How Fast Can You Read?" "How Large is your Vocabulary?" "So You Think You Can Add?" "What Do You Know About Grammar?" Offer men these self-testing devices and then offer them means for improving their skills.

55. Hold a contest between wards or sections, surgery, medical, etc. as to who can arrange and present the best assembly.

56. Organize a group of interested men who, through the assistance of the librarian, will assemble reading information which may serve as basic material for discussion groups which they will lead.

57. Organize debates.

58. Start a series of question and answer hours led by a physician on the topic: "Doctor, what would you advise?"

59. For those who are able to travel, arrange tours to points of interest in the vicinity of the hospital.

60. For those who are not able to travel, have some one familiar with the community talk on any important historical landmarks and on any important historical events which may have occurred in the neighborhood.

61. Offer a course in commercial law. Generally among the patients of the hospital, one or more lawayers will be found.

62. Start a series of talks or articles in the hospital newspaper or broadcast over the public address system on the topic: "Fallacies in the Thinking of People".

63. Have a competent person lecture to the men upon the subject: "The Art and the Science of Love and Marriage".

64. Have a lecturer present, either in person or by the public address system, or through writing, a series of topics, "Fetishes which Effect our Feelings and Thinking".

65. Organize a course in bridge playing and other card games.

66. Organize some talks on the laws of chance, demonstrate with coins, etc. There is an enteresting history of mathematics and gambling which gave use to statistics and which has become a tool of modern science.

67. Arrange a series of discussions, talks, or films on the topic of "Unknown Worlds". Topics of interest here might be: insect life, reptiles, flowers, and the little known scientific facts.

68. Have someone discuss great fallacies and misconceptions which have affected the thinking of the world. For example, the belief by the ancients that there were exactly 1,072 stars--no more, no less.

69. Have a demonstration of color harmony and the color effects in light mixing.

70. Have a series of discussions, articles, etc. on ways to make money.

71. Discuss or have lectures or a series of anecdotes upon the odd and humorous effects of the impinging of modern on primitive life.

72. Prepare a series of topics on how everyday modern inventions work, such as those used in the ordinary house daily. For example, how it is possible to carry on a number of telephone conversations simultaneously over the same wire without getting scrambled.

73. A series of lectures on the history of money would be interesting.

74. What is humor? What makes things funny? Do modern and ancient anecdotes differ?

75. What is the history of sports in which the world today is interested? Who are some of the great characters in the field of sports, today, yesterday, and in antiquity? Arrange a program on this topic.

76. How do we learn? A series of interesting lectures and demonstrations can be given on this subject.

77. How do we learn? A series of interesting lectures and demonstrations can be given on this subject.

78. A consideration of what is fear and how it can be overcome would be interesting.

79. How did the great persons of history make their living?

80. Who were the greatest doctors the world has known, and what did they contribute to medical science and to the art of healing?

81. Promote an hour devoted to imagination. For example, what will life be like 500 years hence? Did the feelings of men and women 500 years ago differ essentially from the feelings of men and women today?

82. Have someone prepare a talk or a series of short accounts on the topic: "Noble Qualities in Despicable Characters".

83. Have one or two lectures presented on the subject: "Transportation Tomorrow". These lectures may indicate a necessity for learning air navigation. If it is true that tomorrow many of us will be operating airplanes of our own, then it will be necessary for us to be able to read aviation maps to determine our position and to plot courses.

84. Take the firing pins out of rifles, carbines and machine guns and have men learn to assemble them blind folded. Make this a contest.

85. Send for or construct blinker sets and teach blinker code on wards.

86. Have patients prepare a map for each ward to trace the progress of the war.

87. Have patients construct a topographical map of combat regions.

BRIGADIER GENERAL J. M. WILLIS: I didn't believe it would happen, but it has. Major Briscoe has stopped on time. I might say now that we are running a little ahead of schedule, and he could have had more time. The next officer to talk is also a representative from the Surgeon General's Office and I take pleasure in introducing Major Barton.

IX. MAJOR WALTER E. BARTON
Reconditioning Division
Surgeon General's Office

The Reconditioning Program will be extended in all Army Service Force hospitals to include the majority of neuropsychiatric patients. This is the opening paragraph of Section IV in Part Two of ASF Circular 175, 10 June 1944. Out of the experiences of the Mental Hygiene Unit of the England General Hospital, of Lovell General Hospital, of Camp Swift Station Hospital and of others and of the Retraining Centers at Camp Lee, Ft. Belvoir and Aberdeen Proving Ground has come the evidence that the psychiatric patient can be returned to duty from a program that embodies the principles of reconditioning. Reconditioning, with its planned activities program, prevents apathy and morbid introspection. It provides a release for anxieties and diminishes the opportunity for preoccupation with the somatic manifestations of emotional disturbances. After several weeks of reconditioning, it is anticipated that many psychiatric patients may be expected to adjust satisfactorily in the service if reasonable care is used in their reassignment to duty.

It is proposed that just as soon as the necessary investigative procedures have been completed that the majority of psychiatric patients will be assigned to the advanced reconditioning sections of station, regional and general hospitals. They will be housed apart from the usual hospital wards. Patients will be organized into platoons, separate from other patients in Class II of reconditioning, will be placed in duty uniforms and grouped, insofar as possible, on the basis of the degree of their incapacities. If it is found impractical to conduct a program of reconditioning for neuropsychiatric patients in any hospital because of the small number of the group, it is suggested that the Service Command direct that they be sent to another hospital or facility. A number of convalescent hospitals will be designated about the country to handle large groups of neuropsychiatric patients in reconditioning. Already patients in the Second Service Command have been sent to the Convalescent Facility of England General Hospital. This number will now be increased. It is anticipated that large numbers of psychoneurotics that do not require hospital care, in the First Service Command will be directed to the convalescent facility of Lovell General Hospital at Ft. Devens and in the Eighth Service Command to the Brooks General Hospital at Ft. Sam Houston.

"Psychiatrists will find nothing new in the principles of reconditioning. For years, progressive mental hospitals have scheduled a full day of varied activities as a part of the treatment of those with emotional disorders. Insistence on self-care, the development of self-reliance, the acceptance of responsibility, occupational therapy, the development of new interests and participation in recreational activities have characterized the efforts to prevent morbid self-preoccupation with disease and disability and to develop instead constructive socializing group interests. The Army Reconditioning Program incorporates these proven principles into the requirements of military necessity.

"The soldier of today is in most instances a highly trained technical specialist. Over a period of a year or more he laboriously acquires new skills in the art of warfare. The successful soldier develops habits of thinking and feeling that permit ready adaptability to new and uncomfortable situations. He learns the importance of constant vigilance and alertness and the equally important art of rapid relaxation when given a moment of opportunity. He finds the will to fight through his identification with the group in their belief in the worthwhileness of the mission and in their interdependence and mutual esteem. The soldier in combat develops the will to fight in the danger and the desperate desire to stay alive. From the fearful surprise that follows the realization that someone is shooting at him to kill and from the flaming anger that follows the sudden death of a friend is distilled the cool efficient fighting machine. Coupled with technical fitness and mental and emotional fitness, effectiveness of fighting men depends upon the development of superb physical condition. It takes stamina to slog through mud, dig foxholes, sleep in them, endure jungle heat and insects, lug heavy ammunition cases and supplies, drive tanks and trucks over rough and

dangerous terrain and to maintain normal response under stress in the face of fatigue and exhaustion.

"Man is indeed still the most important weapon of modern warfare. How can one tolerate the casual attitude toward the trained soldier, convalescent in an Army hospital, that fosters the dissolution of the fighting spirit and fails to recognize the necessity of restoring physical strength before discharge?

"The desire for discharge from the Army and "bucking for a C.D.D." increases as the distance from the active war theaters and the time of hospital stay lengthens. Association with sympathetic relatives, understandibly enough, encourages the thought heard openly expressed by servicemen from overseas, - "I did my share. Now let the other seven million guys get up front." The man on a convalescent furlough observes the patriotic home front workers handsomely compensated for their service carrying on in the comfort of their homes, and returns to the hospital with the conviction that "you are a sucker to say you want to go back. I can be of more service in a war plant doing a job I was trained for." The lack of military discipline in the Zone of the Interior hospitals, its remoteness from the front, and the fact that a man sees others passing daily through its open doors back into civilian life, all contribute further to expressions of resentment at the discomforts of the service and a desire to go home.

"There are the powerful unconscious factors, too, pulling the men away from exposure to danger. The knee continues painful and weak in spite of the surgeon's assurance that recovery is complete. Pains in the back and in the stomach do not improve under the assurance that there is "no organic pathology". The expressed wish of the patient to return to duty, if he could get rid of the pains, does not disguise the underlying problem. Often the interests developed in occupational therapy or the sense of personal importance discovered in orientation courses or the fun of organized sports and games are the beginnings of new group identifications and a desire to go along with the rest back to duty."[1]

PRINCIPLES AND OBJECTIVES OF RECONDITIONING THE PSYCHIATRIC PATIENT

There is first the need to survey promptly each psychiatric patient received in the station or general hospital. Within a week or ten days, at most, the necessary investigative procedures should have been completed, and all patients who do not require intensive treatment or closed ward care may be assigned, as quickly as possible, to the Reconditioning Section. Secondly, the patient's thinking may be redirected from himself and from thoughts and concern with illness to the varied activities in the Reconditioning Program. Thirdly, group psychotherapy, and to a limited extent, individual psychotherapy may be undertaken. Fourthly, group identification and participation in group activities may be fostered and encouraged through participation in the Reconditioning Program. Fifthly, proper reclassification of neuropsychiatric patients that are to be returned to duty is most important. With assignment to duty that the psychiatric patient may be expected to perform, the chances of recurrence are diminished. There is currently a serious and sincere effort to insure the wise use of men in the Army with an attempt to consider both their physical and mental capacity. It is not amiss to comment, however, that in the Army most must expect to be "misassigned" in terms of civilian occupations for if all were properly assigned, just who would be the fighters in the infantry or the artillery men? Classification must always be subservient to the needs of the Army. Manpower must be effectively placed to prosecute the war. Through the intelligent placement of the psychiatric patient oftentimes a man is preserved for useful service that would otherwise be lost through discharge.

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1 "The Reconditioning and Rehabilitating Program in Army Hospitals", Walter E. Barton, Major, M.C., to be published in the American Journal of Psychiatry.

Those that cannot be salvaged for further service must be discharged after completion of indicated therapy. Before they leave the hospital to return to their homes, they must have an understanding of their problem and the need for further treatment and how it may be obtained after discharge. The opportunities for training should be carefully explained to insure understanding. Assistance must be provided by the appropriate government agencies to secure satisfactory job placement.

The Reconditioning Program for many neuropsychiatric patients will constitute their only treatment in contrast to medical and surgical cases where active therapy has given way to convalescent care. The planning of the reconditioning program, therefore, will be formulated and carried out with the approval and active assistance of the psychiatrist.

The following schedule is suggested as a guide to the establishment of a Reconditioning Program for neuropsychiatric patients. By changing the given numbers of patients in groups it will serve equally well as a basis for planning for 50 patients or 1200. While there is provided some free choice of activities, it is intended that participation be compulsory.

SUGGESTED
SCHEDULE FOR RECONDITIONING
OF
NEUROPSYCHIATRIC PATIENTS

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
800-830	Fatigue Details						
830-900	Calisthenics						
900-1100	Occupational Therapy Industrial Therapy and Educational Activities		or		Games, Sports Military Drill Hikes & Marches		Church
1100-1200	Group Psychotherapy		Panel Discussion	Group Psychotherapy	Training Films	Group Psychotherapy	
1200-1300	Luncheon						
1300-1400	Military Education Class	Educational Hour Outstanding Speakers	Military Education Class	Orientation Lecture	Military Education Class	Open	Open
1400-1500							
1500-1700	Games, Sports Military Drill Hikes & Marches		or		Occupational Therapy Industrial Therapy Educational Activities		
1700-1900	Dinner and Free Time						
1900-2100	Movies	Concert	Soldier Shows	USO Shows	Open	Dance	

In order to make it possible to plan a program for large groups of patients many activities must run simultaneously. It is further suggested that the available locations for activities be tabulated in some such fashion as this:

Occupational Therapy Shops
Recreation Hall
Class Rooms, etc.

It is next necessary to break down the activities into groups. The following approach is an example:

Occupational Therapy - Group A

50	Trainees	(2 Instructors)	Handicraft
50	"	(" "	Art Class
25	"	(1 Instructor)	Wood & Metal Shop-Power Tools
25	"	" "	Group Activities such as
150			Model Planes,
			Photography,
			Properties for other activities,
			Training Aids.

Industrial Therapy - Group B

50	Trainees	(2 Instructors)	Gardening
25	"	(" "	Landscaping
50	"	(Assigned)	Construction Projects
25	"	"	Jobs about Post
150			

Music and Drama - Group C

100	Trainees	(2 Instructors)	Music
50	"	" "	Drama
150			

Educational and Study Classes - Group D

50	Trainees	(1 Instructor)	Languages
50	"	" "	Discussion
50	"	(2 Instructors)	USAFI Courses and Study
150			

Games - Group E

150	Trainees	(2 Instructors)	Mass Games.

Athletics and Sports - Groups F and G

300 Trainees (12 Instructor)

25 men are segregated into a unit. Twelve units may exercise at once if sports space is available as follows:

3 Volley Ball courts
3 Baseball diamonds
2 Badminton courts
1 Golf putting and driving net
1 Gymnasium
1 Tennis and goal high
1 Track and field

150 Trainees (1 Instructor) Military Drill

Groups A,B,C, and D, under this plan, would spend the hours between 9 and 11 A.M. in occupational therapy, industrial therapy, or educational activities. In the afternoon, these same groups, at 1500 to 1700 would engage in games, sports, military drill, hikes and marches. Groups E,F,G, and H would be out of doors in the morning, and in the afternoon would partake in occupational therapy, industrial therapy and educational activities. The activities in groups A,B,C, and D would be selected by the patient, but enrollment would be limited to an established quota for each activity. At the end of a week, the student would have the opportunity to change his assignment and elect another class. All trainees would participate in the activities out of doors.

It is suggested that the ward officer make rounds during the calisthenic period. In this way, he can note those who are unable to participate in the full physical training program and excuse any from the activities for the period when he may wish to schedule an individual interview.

Group psychotherapy is probably most effective when the classes do not exceed 50 in number. Psychiatric social workers and clinical psychologists may conduct group psychotherapy if it appears desirable to supplement those held by the psychiatrist. The schedule suggested above provides, four hours each week for group psychotherapy. Experience may show that more hours are necessary.

Three 2-hour sessions each week are set up in the suggested program for military education classes. It is proposed that this period be devoted to selected military training courses directed toward retraining in military occupations. Courses might include such activities as communications, repair and maintenance of vehicles, motor mechanics, Army administration courses, leadership, first aid, map reading, use of weapons and many other military subjects. An effort should be made to select subjects in which the student may actively participate, individually or in a group.

In planning athletics and sports events it is to be noted that the division of trainess into groups of 25 is suggested in order that competition and tournaments may be encouraged. These have been found most effective.

A carefully planned program of recreation is more important with neuropsychiatric patients than with other convalescent patient groups. At least half of the activities scheduledshould provide an opportunity for patient participation.

SUMMARY

1. The Reconditioning Program will be extended in all Army Service Forces hospitals to include the majority of neuropsychiatric patients.

2. A patient from overseas will be sent from the debarkation hospital to the general hospital nearest his home. There a quick evaluation of each case will be made and the necessary investigative procedure completed. Usually 7 to 10 days should be ample time to do this. Soldiers who have been overseas some time, and who may safely do so, may be given a short sick leave to visit their homes and then may be sent directly to the advanced reconditioning section and there be housed in barracks and dressed in duty uniforms.

3. In most instances, reconditioning will constitute the only treatment for this group.

4. A planned schedule of activities embodying physical reconditioning, educational reconditioning, group psychotherapy, occupational therapy and industrial therapy and recreation has been presented.

5. The need for care in reassignment of the neuropsychiatric patient who is to return to duty is stressed.

6. Further details of a program of reconditioning for the psychiatric patient will be the subject of a forthcoming technical medical bulletin.

BRIGADIER GENERAL J. M. WILLIS: We have a few moments left before the lunch hour for discussion of the morning papers.

X. COLONEL THORNDIKE

General McCoach, General Willis, and General Hillman: Some of the things brought out this morning, I think, should be expanded on a little. Someone has mentioned the personnel classification officer and his position in reconditioning. I have been in very close contact with The Adjutant General's Office for the last two weeks relative to the assignment of Separation Classification Officers in hospitals. It is planned that these officers will be placed in all general hospitals to relocate all patients discharged under War Department Circular 164. They are training personnel for this duty as rapidly as they can in their own schools, so I imagine that within two months most of the general hospitals will have such officers assigned. The day before I left, I asked Lt. Col. Esco Obermann, Separation Classification Branch, AGO, ASF Headquarters, how many officers had actually been assigned, and he answered that only seven hospitals had been supplied with such officers.

Colonel Keller again brought out the report of Major Britt given at the England General Hospital conference where he admitted that pes planus had not responded well to reconditioning. I think that statement is too broad and perhaps a reflection of improper handling of all pes planus. We all know that some can be improved.

The problems of small station hospitals and the type of patients they receive, the briefness of their hospital stay, and the lack of personnel to carry this program out, are very real. It is not the intention to recondition patients who remain in the hospital for fewer than seven days. Usually patients should be returned to duty if they are in bed only for one day, two days, or three days, but judgment, of course, as to who will be reconditioned should be entirely in the command of that hospital.

Major Esslinger mentioned Dr. John Powers' statistics on getting patients out of bed a day after operation. Those statistics were reported at the National Research Council meeting which I happened to attend in the middle of March and have been published and released in a restricted classification. That, of course, we must realize, is only a small series of statistics but it may turn out to be a useful guide. We all know that the medical profession is slow to accept any one man's experience. We cannot say it is a proved fact that such is good surgery. We have to await publication of more statistics, more experience, but at least it ties in with the idea that we have relative to reconditioning Class IV patients while in bed.

Major Esslinger also mentioned Canadian statistics or policies that Canadians had established. He was fortunate enough to be detailed to a demonstration in Huntington, Quebec, where the Canadian Medical Department is setting up a retraining center.

We do want them to get military training when they are in the advanced reconditioning section or separated from the hospital, but the Canadian Army separates them much earlier than we do. They move all Class III patients out and have nothing in the hospitals but patients in Class IV. Thank you.

BRIGADIER GENERAL J. M. WILLIS: We still have a couple of minutes. Does anyone else have anything to say?

LT COL JOHN J. LOUTZENHEISER

I have an announcement to make and at the conclusion thereof we will adjourn for the lunch hour and re-assemble in this room at 1:00 o'clock.

Major Patrick called your attention to a change in schedule. You have a memorandum on your desk stating that the group conferences and discussions Saturday, tomorrow, are changed as follows:

Panel discussion will be held in the Officers' Assembly Room, known as A-10, this hospital. I want to remind you again of the necessity of collecting all the questions to be presented there. Questions will be permitted from the floor after we have disposed of the questions that have been turned in. The Commanding Officers and Reconditioning Officers, and others they have brought with them, should attend this panel discussion.

END OF MORNING SESSION

LT COL JOHN J. LOUTZENHEISER: The first paper this afternoon will be given by Major George H. Ivins, Director, Morale Services Division, Ninth Service Command Headquarters.

XI MAJOR GEORGE H. IVINS
Chief, Morale Services Division
Headquarters, Ninth Service Command

The Morale Services Program, in station and general hospitals, will have application to all military personnel. The Morale Services officer will consider the station complement, as well as all patients, in organizing and carrying on the program of Orientation-Education and Information.

Under reconditioning, the Morale Services Officer will view three types of patients in the four classes:

a) men who will return to fight;
b) men who will return to civilian life;
c) men who will remain in the hospital for a long period.

The first group of patients is of primary concern. These men need to be prepared mentally to resume their roles as fighters. The second group of patients, the men returning to civilian life, need an understanding of the part they can play in community life. In both these groups, restoration of confidence in self is essential. In the first, for the purposes of survival and the destruction of the enemy and in the second for the purpose of constructive action. With the third group of patients there is an obligation to provide assistance for individual adjustment to a prolonged period of hospitalization.

The Army is concerned with individual welfare, but in the hospital, as elsewhere, all men do not feel that this is so. The creation of the attitude that the Army does care is basic to success in mental therapy. The Morale Services Officer does not establish this attitude alone.

The duties of the Morale Services in the Reconditioning Program are stated in general terms in WD Circular 261. The circular was written to define the duties of orientation officers in regiments, but its

adaptation to this program is relatively simple when it is understood that greater attention to individual development is necessary. It is for that reason that the Morale Services officer is referred to as the Education Officer. This officer should be mature with considerable experience in teaching and school administration. His duties are not only varied but they involve the use of excellent judgment in meeting and providing for the several types of patients.

In the conduct of the Army Orientation Course ten activities are considered essential for an effective program.

1. The officer meets with all discussion leaders once a week and presents an analysis of the news of the preceding week and introduces the basic discussion topic which will be used by the groups.

2. He arranges for the weekly orientation meeting led by Unit officers or leaders in the various wards.

3. He releases the news with analysis.

4. Establishes several orientation centers.

5. Displays newsmaps, posters, and other orientation material.

6. Publishes material relating to orientation themes in the Camp Newspaper.

7. Arranges for skits, quizzes, and other forms of dramatic presentations. These do not substitute for the regular weekly discussion hour.

8. Schedules weekly meeting of all officers at the hospital, led preferably by the commanding officer. (This was recommended by General McCoach, 19 May 1944.)

9. The Morale Services Officer maintains a working relationship with psychiatrists, ward medical officers, the physical therapist, occupational therapist, chaplains, and Red Cross personnel.

10. From time to time the officer prepares a morale study for the commanding officer of the hospital.

In addition to these ten activities, films such as the "Why We Fight" series, Information Films, G.I. Movies, and Training Films are shown to the personnel. Preceding the showing of each of the "Why We Fight" series an appropriate talk is given. His duties also include the publication of the newspapers, the preparation of a daily news summary, the distribution of materials and the maintenance of the War Information Centers.

The provision of individual and group instruction in a variety of subjects is a major function. Through the Armed Forces Institute hundreds of correspondence courses are available at both high school and college level. For those who are able to work with others, the self-teaching textbooks are available. Instructors for groups using these books can be recruited from among the patients. Foreign language study is available to the individual or the group by means of self-teaching records in Spanish, Portuguese, French, Italian, German, Japanese, Russian, etc. A statement of materials and sources accompanied The Commanding General's letter of 19 May 1944 to all commanding officers.

Tours to places of historic and industrial interest are of real significance. In addition it might be well for the officer to consider the possibility of inviting some of the leading citizens of the state to the hospital. These persons may then discuss with the men, the local people, and their mores, the history of the region, the economic advantages present now and likely in the post war period.

The plastic and graphic arts have been found to have great value in the Reconditioning Program. Normally they should be considered under the heading of occupational therapy, but it is well for the Morale Services Officer to aid in the promotion of the art program. Media such as clay, plastecine, wood, water colors, and oils have unlimited creative possibilities--and therefore a relation to the phase of work we are carrying on.

Within the hospital there are men of varied interests and abilities. With a little encouragement men with similar interests will form clubs to pursue these interests through discussion and study. Newspaper men, lawyers, mechanics and others can use to advantage the time available to refresh their knowledge of their former occupations or hobbies and to learn about new developments. The post war world will welcome men who are informed in their respective fields.

Each situation will reveal additional possibilities for the men. The Morale Services Officer must discover needs and find a way for providing for them. The officer in the development of the education phase of the program has two objectives: to enable men to become more efficient soldiers through profitable use of their time in appropriate educational activities; and to help soldiers prepare for their re-entry into civilian life.

The Morale Services Division will assist in the development and the improvement of the educational phase of reconditioning. Specifically: by the selection and training of officers, by surveying the situation and making recommendations, by assisting the individual officer in organizing and scheduling activities, by periodic inspections of the work in progress, by providing materials such as textbooks, maps, kits, etc., and by issuing memoranda containing suggestions to simplify and facilitate the accomplishment of the mission.

LT COL JOHN J. LOUTZENHEISER: The next paper was to be given by Colonel Williams of the Ninth Service Command Headquarters. He is late in arriving, his train is overdue many, many hours, and that paper will be given tomorrow. Announcement of the exact time will be made later. I will follow with my contribution.

XII, LT COL JOHN J. LOUTZENHEISER
Director, Reconditioning Service and Orthopedic Consultant
Headquarters Ninth Service Command

When we first discussed this paper, I think I was given the subject, "Reconditioning as an Adjunct to Medical Care". I see it is on the program as "Reconditioning as a Supplement to Medical Care". In my opinion, reconditioning is an integral part of medical care, and consequently if we seek to eliminate any lack of interest or to prevent any excessive loss of time in the Reconditioning Program, it should be carefully integrated with the whole program of care for the patient. Patient care does not mean simply providing his orders in the morning, for operative procedure or for his specific medicine and then taking care of him again at night—leaving him to his own thoughts all day. In civilian life that has happened. In the army it is not going to happen any more. Every medical officer recognizes that it is his duty to care for each patient in such a fashion that it will return the individual to full function or to a state which approximates full function as closely as is humanly possible and to do so in the shortest time possible. He evaluates every procedure which is performed as to its relative benefit to the ultimate good. He hopes to overcome every disability and is only satisfied with the restoration of usefulness. He has found that this is accomplished most efficiently by giving personal attention to each and every patient. He has learned that immediate effective care of his patients eliminates apprehension and restores confidence.

After all the therapeutic necessities have been cared for, ways and means are devised to aid the patient on the road to total recovery. In one instance the patient may be returned to full usefulness within a few weeks or months; in others, it may take many months or years to travel the road to recovery. Plans differ for each patient.

The medical officer knows that he is not only caring for a disease or injury, but that he is also caring for the mind and body of the patient. Little good does it do to cure the disease or overcome the disability if we allow events to occur during the course of care that create neurosis and thereby add an unnecessary disability. Psychic trauma is prevented and helpful self-expression substituted for destructive self-interest. The patient's mind is diverted by using every aid to accomplish natural stimulation and desire for further learning. It is then found that the patient is soon absorbed in a new interest with consequent depreciation of his own ills.

Thus the educational and occupational therapy become just as valuable a form of therapy in the convalescent period as a specific drug or operative procedure was in the earlier stages of the patient's treatment. Our medical officers have learned the great value of these activities and have observed the change in spirit in their patient groups where full use of the many agencies which take part in the Reconditioning Program are used.

It is not the intent to create a postgraduate school in a general hospital, but it is our obligation to divert the patient beneficially and, further, to keep him happily informed.

That group of patients which will be hospitalized for many many months must have the opportunity of further learning. The permanently disabled may have to find new fields of endeavor and learn new skills. We will assist them.

The Reconditioning Program offers still another benefit--that of graded and controlled physical development. The chiefs of the various medical and surgical services have devised a program of graduated physical

exercises. These exercises are designed to promote a sense of well-being and a maintenance of muscle tone. Properly controlled and carefully administered, the exercise program is allowed much earlier in the course of treatment than was previously thought wise. The timely value of rest must not be depreciated, but it is possible to overuse this principle. In the past, some patients have been rested for so long a period of time that it could only constitute neglect. The Army demands a better system of care. This system will accomplish reduction in post-operative complications, maintenance of muscle tone, and earlier restoration of full function. During this recovery the medical officer is responsible for the exact type, character and duration of the exercises. Reduction in the number of weak abdominal walls, foot complaints, and sacroiliac backaches following prolonged bed rest has been a commonplace observation. The physical conditioning portion of the reconditioning program has adequately demonstrated its value as a part of medical care.

The remedial effects of both diversional and curative occupational therapy has long been known to be of great value in providing the patient with an absorbing interest. My brief comment regarding this activity is no indication of my feeling in regard to its importance. Occupational therapy is one of the most important of the phases of reconditioning and will become increasingly important as the number of war wounded increases.

A medical officer who has learned to think of his patients in terms of the reconditioning classes soon learns that it is of benefit to his patients to be properly grouped and segregated for their reconditioning therapy. He has further learned that the physical program in the Class III ambulant patients has brought them out into the sunshine and fresh air and has given them the urge to recovery. This officer no longer has wards filled with convalescent patients sitting around, despondent and introspective because they had no other interests but their own complaints.

We hope to demonstrate at this conference what we mean by a medically directed program of reconditioning. You will hear the surgeon, internist, and psychiatrist state their opinions. You will note I said 'their opinions' and it is <u>their opinion</u> that must hold. They are held responsible for the medical care of their patients. Consequently they must know how they want the Reconditioning Program to function in their services. The care of the sick and wounded cannot be delegated. The medical officer must direct and be responsible for it.

Much credit should go, and deservedly so, to the Chiefs of the Reconditioning and all who assist them. Theirs is the arduous task of carrying out essential detail. Without the invaluable aid of the education and physical reconditioning personnel, the trained occupational and physical therapists, Red Cross and civilian volunteer workers and the enthusiastic interest of officer and enlisted patients; the successful operation of the Reconditioning Program would be impossible. I wish to take this opportunity to thank them all for their accomplishments and to assure them that their assistance is needed.

LT COL JOHN J. LOUTZENHEISER: The next paper will be given by Major James R. Patrick, Deputy Director, Reconditioning Service, Ninth Service Command.

XIII. MAJOR JAMES R. PATRICK
Deputy Director, Reconditioning Service
Headquarters Ninth Service Command

General McCoach, General Willis, General Hillman, fellow members of the conference:

I have been requested to announce again - will you please write your questions and hand them in or leave them lying on the desk so we can have a stimulating conference tomorrow afternoon.

I was asked to talk on this topic of counseling, advising, classification and reassignment. At the time I wasn't sure that it had too pertinent a

place on the program, but Colonel Thorndike in his remarks on separation classification has paved the way for what remarks I have to make. With this in mind, I will talk about some of the phases of counseling and advising for reassignment, and also for discharge under separation classification. In order to do this I would like to recapitulate a moment the process by which men have come into the Army so that I can tie up the remarks I have about separation and reassignment with initial classification.

Initial classification of enlisted men in accordance with AR 615-25 was and is an attempt to utilize manpower most effectively in the Army. The general objectives of proper classification are intended to improve Army efficiency, individual and public morale, and this process became the means by which a proportionate distribution of intelligence, educational background and skills would be given to all units in the numbers needed. But, above all, classification and assignment were to determine that combat units should receive priority of men with physical stamina, leadership qualities, and previous combat experience.

Some factors that have hindered successful initial classification are physical handicaps of men inducted, distribution schedules, substitutions, and Officer Candidate Schools which had to be filled.

Service Commands were and still are responsible for initial classification. The phases of classification break down into testing, interviewing, classifying, coding and punching record forms, and assignment. A word about each phase is necessary for the discussion of this subject in relation to hospitals.

1. Types of Testing:

a. General tests such as AGCT and non-language; individual tests such as Wechsler's, visual classification, etc., are used to determine general abilities.

b. Aptitude tests, mainly mechanical and clerical, are used.

c. Trade tests: Oral, performance, and written

d. For the purpose of aiding interviews, personality inventories, pencil and paper tests, Rorschach and others have been developed.

Each test was standardized and norms established with critical scores given.

2. Interviews: The interview is a planned and controlled questioning with a view toward securing obhective data to be used in classifying and assigning a man to duty. Reliable interview results depend largely upon the intelligence and personality of the interviewer. The interviewer must be familiar with dictionary of occupational titles, of job families, and their breakdowns in civil life, their equivalents in Army specialities, and the tables of organization of jobs in the Army.

3. Classification: Guided by the test results and by the interview, the man is classifed with the following items recorded:

Name, marital status, intelligence, education, service command of induction or enlistment, qualification in sports and entertainment, main civilian occupation, hobbies, leadership, previous military experience, skills, service schools attended, and lastly, whether or not the man is capable of general or limited assignment.

4. Coding: All of these data, as you know, are recorded on WD AGO Form 20, and each man is given a "potential", a "semi", or "skilled" rating. The man is then said to be classified and is ready for assignment to basic training.

5. Assignment: On the basis of distribution schedules from the AGO, men are sent to Basic Training Centers and from there to the various arms or services. We cannot follow them further at the moment.

Errors were made in initial classification. The rapid growth of the Army demanded many substitutions even after correct classification and assignment were indicated. Officer personnel of Ground Forces were

not indoctrinated as to the meaning of Selective Service. Consequently, this system of personnel assignment has broken down in many instances. But assuming that a man was properly classified and assigned and that he subsequently earned a military specification serial number and was sent overseas and wounded in combat and now finds himself in a general hospital, what can classification and counseling do for him there?

COUNSELING, REASSIGNMENT AND SEPARATION CLASSIFICATION

Let us review the classes of patients for counseling purposes. For this purpose, there are four categories of patients:

1. Those who upon recovery will be qualified to return to former military duty.

2. Those who are not, according to their medical history, able to return to their former duty but are qualified for limited assignment. These men need to be studied for reclassification and reassignment.

3. Those who, according to competent medical opinion, are qualified for permanent limited assignment only but who, if battle wounded, by virtue of War Department directives, may elect a CDD.

4. Those who are handicapped to the point of not being able to render reasonable service and are eligible for CDD.

First Category: What kind of counseling and advice does the group who will, upon recovery, return to their former duty status need? Below are listed some of the things upon which these men may need and want advice in addition to regular medical care while convalescing in hospitals:

1. Information regarding why changes have necessarily taken place in this country during their absence. Many of these men have built up fictitious images of home and loved ones while in foxholes. Disappointments and bitterness may result upon finding their fictions are not true.

2. Information and education regarding personal problems of an emotional nature. Advice here may merely be throwing light on the convalescent's problem in order that he may assimilate his emotional experiences.

3. Information about the opportunities for self-improvement while convalescing.

4. Information regarding the manpower needs of our country and of each man's responsibility in meeting these needs.

5. Information that will aid the soldier in seeing and understanding the character and behavior of the American people and the role we are playing in this war and may play in world affairs in the post-war period.

6. Information regarding religious problems.

Counseling and advice on the above named problems, in addition to the physical and occupational therapy and educational reconditioning should go far toward returning this group to duty with healthy mental attitudes along with well bodies.

Second Category: Counseling on similar problems as enumerated above is required for the men who are qualified for limited assignment. In addition to this information, however, these men have to be analyzed to determine what skills, potential or developed, that they have and that the Army needs. What training is necessary in order to give them a new assignment. This will require expert analyses from the point of view of medicine to determine each man's physical limitations and the kind of handicap in relation to his anticipated duty. Classification of each man's skills, knowledge, and interests in relation to his anticipated assignment is likewise necessary.

Third Category: Section IV, ASF Circular No. 114, dated 25 April 1944, modified WD Circular No. 293, 1943, as amended by Section II, WD Circular No.100, 1944. Since publication of ASF Circular 114, WD Circulars No. 293 and No. 100 have been superseded by WD Circular No. 164. ASF Circular No. 114 now refers to 2e, WD Circular No. 164, and more recently, WD Circular No. 212 in governing the utilization of enlisted personnel undergoing hospitalization within the United States as a result of wounds received in battle.* The War Department continues to recognize permission granted enlisted men to obtain a discharge if, as a result of their wounds, they are permanently qualified for limited duty only. But the manpower need is so great that if these men can be employed in a reasonably useful way, they are urged to remain in service. Here indeed is the opportunity for both medical and classification personnel to do the highest form of classification for reassignment; namely, that of matching men with physical and mental limitations beyond that which is natural to some useful job. In addition to conseling problems already mentioned, these men need special care.

If the Reconditioning Program reaches the point of arousing the enthusiasm of men and if classification and assignment do a good job in matching the man's assets to the Army job demands, many of these men will be encouraged to remain in service because they will be doing things for which they are qualified and find interesting. If, on the other hand, the classification and reassignment process is 'bungled,' the specialized abilities of these men may be lost to the Army. Certainly it takes a specialist working closely with the medical staff to be able to encourage a man who has lost an eye or a hand to determine the kind of job in the army that will not only serve the immediate purposes of winning the war, but may lay the foundation for this man's life work subsequent to his discharge into civil life. For men to remain in service under these conditions, reassignments must interest each man; chance will not take care of this problem. It must be thought through and planned.

Fourth Category: If a man has a useful skill but is eligible and elects discharge, it is required in this Service Command that he be reported to Civilian Personnel Officer so that his services may be utilized in the war effort either as a civilian or with the Army in a civilian status. However, the War Department has determined that this man too shall be advised. The Separation Classification Program now begun in some general hospitals is only the beginning of what is to come when demobilization gets under way in the large Separation Centers.

Already within this command Bushnell has a Pilot Separation Classification Section in operation. The personnel of this Classification Section, working under and with the Director of Reconditioning, consists of an officer qualified as vocational and educational conselor, and enlisted or civilian personnel qualified as occupational rehabilitation counselors. This personnel, in addition to its counseling duties with CDD patients, is advising and making recommendations for reassignment of battle casualty enlisted men and officers coming under ASF Circular No. 114 and WD Circular No. 161. We continue further the discussion of counseling CDD's.

War Department objectives of Separation Classification are as follows: (a) to provide prospective employers and civilian agencies, such as counseling agencies, employment agencies, and the Veterans' Administration, with authentic information on what the Army knows of the experience and qualifications of personnel separated; (b) to provide each soldier with relevant and appropriate information regarding job opportunities and educational possibilities; and (c) to aid each soldier in appraising his occupational assets. The ultimate aim of separation classification is to assure that servicemen and women are given guidance which will be of help to them in making the transition to civilian life and in later adjustment. To accomplish this, procedures outlined for separation classification personnel are similar to those of initial classification in that the interview and tests play an important role.

The added features are examination of military records, furnishing information to men on vocational and educational opportunities, and notifying employment agencies of a man's assets and liabilities. Here again the medical profession plays a most important role

*WD Circular No. 217 dated 1 June 1944 and ASF Circular No. 175 dated 10 June 1944 bring the matter of utilization of battle casualties up to date.

in appraising the discharged man from the point of view of his physical and mental stamina. The medical personnel is in reality classifying for placement whether or not it is called that. After his physical and mental status is determined, the personnel psychologist or classificatin officer then makes the analysis of the man's intelligence, learning abilities, and skills. In the advice given each man the attempt is made to match these skills to a potential job.

Thus we see that the cycle is completed. The Army made use of what knowledge and skills the individual had prior to induction. It taught him new skills and improved many already present. Parenthetically it may be said, never has an Army given its men so much training and schooling as the Army of the United States. Being an ethical and democratic institution, the Army is now willing to give to society all of the information regarding the men which it has trained and used. Of course, there have been many "expendables", partial and complete.

Initial classification then captures a man's past civilian experiences and adapts these experiences to Army needs. Separation Classification captures the military experiences of each man and turns this information back to business and industry for its benefit in re-employing these men. Today this process of counseling for separation is going on primarily with the few who are discharged from hospitals. When victory comes tomorrow and the big demobilization process begins, this work will be carried on primarily at Separation Classification Centers. In either case, it is proper for you and me to note that the key personnel in this process are medical officers who make the first appraisal of men to be discharged, and then it becomes the classification officer's job to analyze aptitudes and skills and to make the knowledge of these skills available to industry.

As we complete this cycle, I should like to call attention to what seems to be a significant step in medical classification. The personnel psychologist has long since been concerned with objective measures of abilities, learning, motivation, and skills. You are now witnessing the analysis and classification of men from an objective viewpoint in medicine.

PHYSICAL CLASSIFICATION

Memorandum WD-44, dated 18 May 1944, has pointed the way. Here the medical profession is directed to classify men according to a physical profile plan so as to meet the scheduled demands of Ground, Air, and Service Forces from the point of view of physical abilities and stamina. This classification is on the following basis:

Lower extremities: Functional use, strength, range of motion, and general efficiency of feet, legs, pelvic girdle, and lower back (sacral spine).

Hearing (including ear defects): The auditory acuity is to be considered as well as organic defects.

Eyes: The visual acuity is to be considered as well as organic defects.

Neuropsychiatric: Emotional stability, personality and neuropsychiatric history and findings will be considered.

The profiles that accompany the above categories are for group classification but each man has to be medically appraised and fitted into his group. The medical profession and classification officers are furthering techniques that appraise all phases of man. These techniques may be useful to business and industry in the post-war period. A few words of caution and some remarks on the psychoneurotic patients are now in order.

WORD OF CAUTION

A letter from the Surgeon General's Office, 29 May 1944, states that men returning to units from the hospitals have not made satisfactory adjustments because in some cases they have been ill advised regarding their physical handicap by medical officers, or have been given copies of medical recommendations addressed to their commanding officers. It is the policy of the SGO for medical staff not to give estimates of future situations or assignments to enlisted men being discharged from hospitals. This does not preclude the medical staff discussing the individual's physical condition with him, but it does mean that statements concerning definite future assignments will not be given to the man himself. When questions are asked regarding future assignments, the medical staff should say: "Appropriate recommendations will be made to your commanding officer regarding your future assignment." This letter is specific about other things. Men should not be told that they are not fit for overseas duty; neither should they be told they cannot hike. What is important is that considered judgments be written down for those in authority over these men, and the men themselves not told these recommendations in advance.

People tend to remember what they want to remember, and while in a state of convalescence, no doubt men select out of well-meaning contexts certain statements which later cause confusion and lower men's morale.

This advice is also particularly applicable to classification and instructor personnel. Ill-considered statements should not be made to men regarding their future assignments. To summarize, both medical and instructional staff should make statements that are supported by facts, regulations, and well-considred clinical judgments. The temptation is great, no doubt, even for professional people to talk in a manner that will make the patient feel good at the time. What has to be remembered is that we represent an insitution--the Army--and that what statements are made should not be personal but should be consonant with the best medical practice and with the regulations. Misinformation and bad judgments cause men to lose faith in the Army and in the Government and tends to discredit lawfulness. Lawfulness is one of the things for which we are fighting.

Many of the men in hospitals are too close to their war experience to have a clear perspective. In many cases their reactions are highly charged with emotions; therefore, their thinking may not be as clear about their future responsibilities and opportunities as it will be after a period of time. They may not, as a result of this, come to grips with specific problems that confront them regarding reassignment or for finding a job upon being discharged. It is the responsibility of all personnel to help these men formulate their specific questions and answers relating to this important phase of their adjustment. On the other hand, the rold of the counselors is not one of telling CDD patients what to do. The role is one of laying before these men the facts about the opportunities that may exist in this or that or other field of endeavor. Further, they should be given the facts about the agencies that will arrange for placement on jobs. Information should be specific and correct. General statements are not sufficient in counseling men. It is wise to write down for a man being discharged the man's name and street address to whom he is referred for a job. If, upon discharge, a man has a definite place to go to see a specific person, he is much more likely to feel that the Army has discharged its responsibility in guidance. This means diligence in job opportunities. It must be a continuous process on the part of the counselor.

PSYCHONEUROTICS

This paper has turned out to be counseling to the counselors. A word need be said about mental maladjustments.

Experience has shown that the majority of patients with mental and emotional upsets are benefited by a planned program of activities which prevents apathy, morbid introspection, and pre-occupation with somatic manifestations of emotional disturbances.

It is claimed by some psychiatrists that prolonged hospitalization tends to fix symptoms rather than alleviate them; thus the best of the lot of these patients should be salvaged and housed in a separate reconditioning annexes or center in accordance with TB Med 28, 1 April 1944, which gives an outline of the plan for reconditioning them. The psychoneruotics are under the guidance of the psychiatrist and selective assignment to duty should be as provided by War Department directives.

We close this paper with a quotation from Major General Dalton, taken from Personal Affairs Bulletin No. 4, 20 May 1944. It is applicable to those of us in reconditioning and in classification. We quote: "A case should not be regarded as closed by the mere referance of applicant to another agency. It is our duty to see to it that there is a satisfactory solution of the problem before any case is ever considered closed."

Thank you.

LT COL JOHN J. LOUTZENHEISER: I would like you to refer to your card to determine what group you belong to by that card. The A group with Sgt. Phillips is meeting in the back of the hall; the B group, led by Lt. Belding will organize here by the Fort Ord and Camp Beale exhibit in this side of the hall; the C group led by Lt. Schummers will meet by the Bushnell exhibits.

END OF AFTERNOON SESSION

COLONEL L. R. POUST: During the day you have had explained to you more or less what was believed to be the ideal in regard to reconditioning--that was really what occurred this morning. This afternoon we endeavored to demonstrate how some of those activities have been carried out in Classes IV and III, and sections of Classes II and I. This evening we are going to have the Chiefs of three of our Services contribute something of their ideas about reconditioning activities pertaining to their specialties. Colonel Zeifert, Chief of the Neuropsychiatric Service of this hospital, will give you his impressions of reconditioning in the management and in connection with his NP cases. Colonel Zeifert:

XIV. LT COL MARK ZEIFERT, MC
Chief, Neuropsychiatric Service

General McCoach, General Willis, General Hillman, Colonel Poust, Ladies and Gentlemen. The Neuropsychiatric Reconditioning Program was instituted at Hammond General Hospital fifteen months ago with the organization of an occupational therapy shop and a physical training program in the closed ward area. In May, 1943 the program was expanded to embrace the open ward neuropsychiatric cases as well. By September, 1943 a special shop was opened for use of non-psychotic patients. A few months later a third and larger occupational therapy shop was organized to provide room for more patients and a greater variety of crafts and technics.

The Occupational Therapy Section here is directed by the Chief of Neuropsychiatric Service. He is assisted by a member of the Surgical Service. The actual therapy is administered by the head occupational therapy aide, a woman whose natural aptitude and skill are enhanced and complemented by years of pre-military experience as chief occupational therapist in a 3000 bed civilian hospital. She has eight assistants. We do not permit treatment by untrained people. Occupational therapy recuires the services of graduates of recognized occupational therapy schools. Treatment is by written prescription of a medical officer. Patients are interviewed by the head aide and given appointment cards for specific hours of treatment. This serves two purposes. It avoids overcrowding of the shops and also prevents the exposure of patients with hyperacusis to noisy apparatus.

All neuropsychiatric patients are initially interviewed, examined, and classified on admission. They are then told that treatment is to start at once and that occupational therapy has been prescribed for them. The nature of this modality is explained as well as the fact that the prescription is individual and is prepared by his physician. We find that the intelligent patients--regardless of the degree of conflict--accept and benefit from occupational therapy more than those of inferior intellect. Officer patients from our Neuropsychiatric Service are most enthusiastic about the benefit of this method of treatment and their enthusiasm and optimism pervades the shop atmosphere and exerts a beneficial effect.

Early in our experience we learned the necessity of providing special types of activity and a special shop for psychoneurotics in whom the onset of symtoms was associated with a combat situation. Because of the marked startle-pattern of these individuals, it was necessary to provide either a so-called "quiet" shop or a "quiet" period. We learned that these people could not tolerate the noise of power-tools, of metal-tapping, of carpentry, of motor mechanics, or the grinding of gears. These soldiers have simply become hypersensitive to noise and for them we provide the crafts which recuire neither sudden movements nor application of noisy technics. These are our severely sick patients--most of whom have been subjected to treatment in many hospitals overseas--and the vast majority of these patients are returned to civilian life. These patients are eager to be treated, respond well to moderate discipline and enter into calisthenics, orientation lectures, and group psychotherapy willingly.

Patients at Hammond are divided first into the psychotic and non-psychotic groups. By and large the psychotic group is separated from the Service. These patients are assigned to occupational therapy within twenty-four hours after admission.

While other therapy is being administered, such as the various forms of shock and psychotherapy, the reconditioning process is begun. In addition to occupational therapy there are daily periods of ward police and sanitation, gardening, free athletic activity, such as shooting baskets, punching a striking bag, shuffle-board, ping-pong, croquet, as well as organized calisthenics, volleyball, and football. Regular parties are held weekly at which patients are prepared for another aspect of nonmilitary activity. The mess tables are covered with tablecloths and set with fresh-cut flowers from gardens tended by the patients. Here they are encouraged to readjust themselves to the customs of civilian life. Movies are shown on the ward three times per week. We find that orientation lectures as ordinarily administered to groups are not effective with these people. As these psychotic patients recover, the Ward Surgeon in his psychotherapeutic talks reorients the individual. Every effort is made to show the patient that his inability to make a military adjustment does not preclude his ability to serve in the war effort outside. He is urged to plan on going to work as soon as he leaves this hospital or the Veterans Facility, and a number of our patients have contacted friends and former employers and secured offers of positions. This applies, of course, to the milder psychotics--who though unfit for further military service--are able to maintain themselves in a situation where strict compliance with discipline is not required.

In a few instances, such as the toxic psychoses and cases of traumatic delirium, the patient is subjected to a similar treatment but is transferred to the open neuropsychiatric wards and there reconditioned for duty, when the acute phase of his illness is over. So much for the psychotics.

On the open neuropsychiatric wards the problem is different. Here we attempt to segregate patients into those who can be reclaimed and those who obviously must be CDD'd. The latter are given a program of reconditioning very much like that given to the psychotics with the exception that more group psychotherapy is used, more calisthenics are prescribed, and the patient participates in group orientation activities. These patients are all segregated in a separate ward to avoid psychic contamination of the reclaimable patients. When the patient's discharge is imminent, the ward officer sees the patient individually and re-emphasizes his importance to the war effort, and his function and importance as an integral unit of his community. The patient is again impressed with the fact that there is no relationship between readjustment in civilian life and his difficulties in adjusting to the military situation.

The remainder of the psychoneurotic cases are divided into the mild or situational and the moderate types. The former are worked up quickly and given individual psychotherapy. We find that in such cases referral to the Chaplain or Red Cross for adjustment of extrinsic factors and a few psychotherapeutic sessions are sufficient to permit entrance into a full reconditioning program. During this time he receives prescribed occupational therapy and partakes of calisthenics and orientation talks and films. Passes are given liberally and the soldier is encouraged to believe that this is an index of the mildness of his condition and his ability to get along outside the hospital. As soon as possible the soldier is transferred to the Reconditioning Section for completion of convalescence.

Doubtful and moderately severe psychoneurotics are treated in a special group, for rehabilitation to duty within the zone of the Interior. The program laid out here consists also of occupational therapy, group psychotherapy, calisthenics, group games, orientation talks and films, and modified pass privileges. These patients are kept in the hospital--rather than in the Reconditioning Section--as their inability to compare favorably with the physical and psychologic standards of the Group One patients serves as a handicap to both groups when they are intermingled. In accordance with existing directives they are referred to the Classification Officer with suitable medical recommendations when they are ready to return to duty.

Generally speaking, we have found that the program demands not only efficiency and professional skill from all those connected with it, but also enthusiasm and interest. We, therefore, require all medical officers to visit the occupational therapy shops, calisthenic periods, and other activities at regular intervals. The patient does not benefit from activities which do not appear to interest the doctor, and, on the contrary the appearance of his ward officer seems to stimulate and redirect the patient's interest in recovery. However, once the patient reaches the Reconditioning Section we feel that there must be as little contact as possible with the hospital and its memories. A neuropsychiatrist is assigned to make one visit per week to the Center to consult with the Medical Officers there, and to pass on the ability of patients to return to duty. We feel that if the soldier is to return to duty, he must learn to live as he would on duty, and we are acutely aware of the fact that daily association with the psychiatrist is not conducive to the performance of duty in the field. To be prepared for such duty the soldier should have no more special medical facilities than he would have in his battalion, and the time to adapt himself to that type of duty, is now. When a soldier approaches his fifteen-mile hike in the Center, daily contact with the psychiatrist--or the orthopedist--may only serve to accentuate painful feet.

In closing it must be repeated that we at Hammond are enthusiastic about the Reconditioning Program in neuropsychiatric cases. We know, however, that once such a program is routinized, made to work "by the numbers" or the patient made to fit the prescription, the plan is inherently doomed to failure. On the contrary, our experience has taught us that as long as the program is individually prescribed for each individual patient by competent medical practitioners, the soldier, the Army, and the community derive great benefit.

COLONEL L. R. POUST: Thank you, Colonel Zeifert. This morning I mentioned the fact that you would see occupational therapy in action if you visited the closed psychiatric area, that is, Ward C-3, and I am sure you found things of considerable interest if you did find the time to go down there. The next speaker is the Chief of the Medical Service, who at the present time is serving as the Medical Director of the Reconditioning Division in this hospital. Colonel Cheney has had considerable experience in internal medicine, in fact, in all kinds and branches of medicine. He is the Chief of our Medical Service and he is going to give you his impressions of reconditioning in connection with our general medical and malarial treatment programs. Colonel Cheney:

XV. LT COL GARNETT CHENEY, MC
Chief, Medical Service

Evaluation of proper physical reconditioning for the Medical Branch patients is not easy. Broad, more or less theoretical generalities are not applicable. Not alone must the therapeutic exercises for our patients be broken down into a number of appropriate grades, but medical diseases must also be subdivided into types and stages. Finally a great deal of individualization is necessary in many cases in order to permit the ward officer to select suitable early exercises.

I have chosen seven illustrative medical conditions for tabular presentation by slides. These tables show what we are doing to recondition Medical Branch patients at Hammond General Hospital now, and may serve as a guide for others.

TYPES OF RECONDITIONING FOR SELECTED MEDICAL CONDITIONS

THE DISEASE AND STAGE	ORIENTATION THERAPY	OCCUPATIONAL THERAPY	PHYSICAL EDUCATION (GROUP)
1. Malaria			
a. Bed patients, acutely ill	None	None	None (IV)
b. Ambulatory with parasitemia	≠	≠	None (Or early III)
c. Symptom and parasite free	≠	≠	Early and late III, 4-6 wks Then II and I, 6-8 wks
2. Peptic Ulcer			
a. Bed patient with symptoms	≠ -	≠	None (IV)
b. Ambulatory with symptoms	≠	≠	Early III, 2 ≠ wks
c. Symptom free, X-ray positive	≠	≠	Late III, 4-6 wks
d. Symptom free, X-ray negative	≠	≠	II, 4 wks
3. Rheumatic Fever			
a. Bed patient with fever	None	None	None (IV)
b. Bed patient, fever free	≠	≠ -	None (IV), 8-12 wks
c. Ambulatory	≠	≠	Early and late III, 4-8 wks Then II and I, 4 ≠ wks
4. Pleural Effusion			
a. Bed patient with fever	None	None	None (IV)
b. Bed patient, fever free	≠	≠	None (IV) 4 ≠ wks
c. Ambulatory	≠	≠	IV to early III, 12≠ - wks Then late III, II, I, 4-8 wks.
5. Hypertension			
a. Severe	None	None	None (IV)
b. Moderate	≠	≠	None (IV)
c. Mild, ambulatory	≠	≠	Early III, 2-4 wks
6. Heart Disease			
a. With heart failure	≠ -	≠ -	None (IV)
b. Ambulatory with symptoms	≠	≠ -	None (IV)
c. Ambulatory without symptoms	≠	≠	Early and late III, 4≠ - wks.
7. Asthma			
a. Severe, frequent attacks	≠	≠ -	None (IV)
b. Mild, rare attacks	≠	≠	Early III, 2-4 wks
c. Free of attacks	≠	≠	Late III, II, 4-8 wks

There are two further points I would like to make: one is that we have felt that the ward officer and nurse on the ward, because of their daily and prolonged contact with the patient, are often best able to discern the special aptitude of a patient, at least in the beginning, and what type of diversional, occupational, and prevocational therapy should be indulged in.

Also, there is something I think we should guard against--too much time spent in reconditioning, thus possibly unduly lengthening the period of disability. We have certain patients who come in with a brief illness who may be returned to active duty without going to the reconditioning center. One such disease is acute respiratory infection, perhaps pneumonia, which is of brief duration and not very debilitating, and after a certain amount of exercise on the wards, I believe that certainly not much physical reconditioning in the center is indicated, if any.

To summarize, all I have covered is a few medical conditions and the way we handle them at Hammond. We are not altogether satisfied with what we are doing. We are changing our program from time to time in our groups of cases. We hope to run control groups later on, but that offers a great deal of difficulty as you know. However, I think our results have been very good in the majority of cases where they have been carefully selected and individualism has been possible. Thank you.

COLONEL L. R. POUST: Thank you, Colonel Cheney. The last speaker this evening will be a man whom you have encountered several times today, because he has helped very materially in putting on demonstrations. The last place you saw him was at the swimming pool. Colonel Shaeffer came here comparatively recently as Chief of the Surgical Service, but he is very enthusiastic in regard to the splendid results we can obtain and do obtain in reconditioning our surgical cases. Colonel Shaeffer:

XVI. LT COL J. R. SHAEFFER
Chief, Surgical Service

This afternoon you reviewed demonstrations of physical reconditioning programs held on three surgical wards containing different types of cases in varying degrees or stages of convalescence. These demonstrations were carried out by especially selected patients who performed under the guidance of specially trained personnel. Each case had been thoroughly reviewed with the instructor. The nature of his illness, his physical limitations and exactly which exercises he could safely perform without endangering his basic condition or producing unwarranted stress or strain on his specific injured part, whether traumatic or surgical, were all discussed in detail beforehand. Obviously such an arrangement approaches the ideal, for it is a fundamental truth that any reconditioning program, if it is to attain its desired result of returning the sick or injured soldier to health and duty in better physical condition and perhaps to do so sooner than is the usual expectancy, must be based on sound medical principles and under the constant supervision of the responsible medical officer. It is the accepted duty of the doctor to his patient and no other skill or training can replace his understanding of the pathological processes involved or the physiologic disturbances peculiar to any individual case. This is the first prerequisite - namely, constant Medical Supervision.

There can be no question of the importance and necessity of the early and continuing application of the ideas involved in physical and mental reconditioning following any period of confinement or incapacity. The early return of a temporarily lost feeling of physical sufficiency, accompanied by a sense of satisfaction incident to accomplishment, is the need and subconscious desire of every patient regardless of his affliction. Experience dictates that he can be encouraged and aided in his progress by a reasonable understanding of the nature of his illness, his probably prognosis and expectancy, accompanied by simple and understandable instruction in just what he can do to help himself. Everyone enjoys health. Every soldier with few exceptions would prefer not to be in a hospital. Being there, his individual problems take precedence over any other problem and any program must be his program. Granted that the above concept be true, any such program regardless of its nature and apparent soundness, must of necessity appeal to the reason and understanding of the individual if it is to survive and be successful. This then becomes the second prerequisite - namely, INDIVIDUALIZATION.

Furthermore, not only must the specific procedures be correct and harmless, but they must appeal through diversional interest or a competitive spirit to the latent desire of each individual to succeed and attain a given objective. It is the opinion of the speaker that the present soldier-patient insists on being treated as a man, that he wants no part of any program which smacks of idle theory or armchair fancy. The program must not only be realistic, but entertaining. This necessitates constant revision of plans, and great imagination and ingenuity on the part of those responsible. The combined efforts of the medical personnel, the physical instructors, the occupational and physical therapists, the Red Cross workers, - in fact the staff in general, is necessary if interest is to be maintained. The soldier-patient of today has traveled far, is experienced, is critical, is not easily satisfied. In short, he is tough and certainly is resistant to ordinary salesmanship. Any program must first answer to his satisfaction the question - "Why?" This is the third prerequisite - namely, Maintenance of Interest.

The problems incident to the operation of a reconditioning program on any surgical service are many and varied. You have noted that we begin our program as early as is practicable following the initial treatment of the injury or surgery. You noted that we use a post-operative Recovery Ward to which all cases are referred from the Surgery and it is here that health exercises are to minimize chest complications incident to anesthesia, and early active lower extremity motion to prevent possible phlebothrombosis and its sequel - embolism. This ward is supervised by especially selected personnel and it is the order that the Surgical Officer of the Day personally supervise these exercises on

his early evening tour. Patients are removed to a ward of their respective section, as a rule between the third and fifth postoperative day. Not until such time as it becomes medically safe to do so is he placed in whole or in part in the hands of the ward physical instructor. As he gains in strength and health, his planned activities are increased until finally he is prepared for out-of-ward exercises or the Reconditioning Center.

As has been emphasized, each new case is approached according to the extent and nature of his injury or operation. No attempt is made at gross classification, each being integrated properly within the type of illness he has suffered. For example, there can be no "set of exercises" for "hernias." The direct, or incisional, or recurrent hernia is far different from the common simple oblique hernia; and furthermore, the surgical procedure being essentially a plastic repair of an anatomical defect, the obese individual frequently presents poorer quality of tissue for such repair than his thinner and more muscular brother. He will of necessity require a longer period of protection from other than the simplest exercises. Again, postoperative abdominal wounds, kidney wounds or chest wounds per se, must be approached far differently than traumatic or operative wounds of the extremities wherein one member usually is incapacitated and commonly encapsulated in plaster of paris bandages. The latter cases, comparatively, can soon be subjected to other bodily activity and quite reasonably profit by such. Certain orthopedic and neurosurgical cases, many of whom are bed confined for long periods of time, can without doubt be made healthier and happier by a well organized and a well administered Reconditioning Program. There should be little question that such normal physiologic stimuli are beneficial to the reparative mechanisms and distinct aids to the necessary psychological adjustments so frequently, although unintentionally, overlooked.

One well proven advantage of such a program has been observed among the surgical patients who have finally advanced to reach the Reconditioning Center. Here all cases are examined at regular weekly intervals by the Chief of the Surgical Service with chiefs of the respective sections. This trial period of duty wherein the patients are grouped according to their residual disabilities and their training has continued, as you will see tomorrow, under properly qualified leadership, has been of inestimable value both to the patient and to the doctor. This "return clinic", to borrow a term from civilian experience, is the nearest approach to a satisfactory "follow-up" of surgical cases, so essential to scientific progress, yet devised by military medicine. Until this present policy was established any attempt at evaluation of "end results" has been pure guess work.

In conclusion let me repeat, that it is our opinion and experience that that portion of any reconditioning program which deals with the functional repair of the diseased or injured part, is the province of the medical officer and that "in addition to his other duties" he must see to it that this professional supervision be available at all times; that during any period in the progress of planned training and education, the treatment of the part is properly evaluated and integrated with the treatment of the whole.

COLONEL POUST: Thank you Colonel Shaeffer. Now comes the time that has been allotted to the examination of the exhibits. Through the efforts of the Service Command Surgeon a number of outstanding exhibits have been assembled here, and I am sure we can all learn something from studying these exhibits and applying them to our own work shops. Throughout this auditorium there are the exhibits from the various other general and station hospitals in the Ninth Service Command. In Building B-8, the Hammond Hospital exhibit is available to be observed and studied, if you care to, and that will take you from approximately 8 to 9 o'clock. Now at 9 o'clock all of you are the guests of the staff of Hammond General Hospital at the Officers and Nurses Club. There we will endeavor to entertain you. There will be some dancing. However, there will be liquid refreshments and we hope some good fellowship.

I have been asked to make one other announcement. Be sure to leave questions for the round table panel discussion for tomorrow afternoon on the table at which you are now seated.

Colonel Loutzenheiser has something to say at this time.

LT COL JOHN J. LOUTZENHEISER: The first exhibit I would like to have you all see is a motion picture on physical education.

(Motion Picture Followed)

END OF EVENING SESSION

16 June 1944

BRIGADIER GENERAL J. M. WILLIS: Gentlemen, I have one announcement to make this morning and I will turn the meeting over to Colonel Loutzenheiser to carry on. Immediately after the close of this conference, I expect to remain here overnight, and I should like to have a short conference with the commanding officers of both general hospitals and station hospitals. It won't take long, but I have just a little information that I would like to give them.

LT COL JOHN J. LOUTZENHEISER: The first paper this morning will be presented by Captain Hogensen, Assistant to the Director, Special Service Division, Headquarters, Ninth Service Command.

XVII. CAPTAIN P. N. HOGENSEN, AUS
Assistant to Director, Special Service Division, HNSC

General McCoach, General Willis, General Hillman, and fellow conferees. After last night's performance of the program at the Officers' Club, I probably should not say much about Special Service activities because the program last night, in my estimation, was excellent. But to put on such a performance as you have, hospitals in the Ninth Service Command need the assistance and cooperation of other units beside your regular groups, namely Red Cross, Morale Service Division, Special Service Division, and other service units. I am going to cover briefly what the Special Service Officer can do to help the program. First of all, the mission of the Special Service Officer is to develop and carry out to the fullest extent a Special Service routine based on the needs of the troops of the post. To supply what is most needed to meet these different requirements, the Special Service Officer has as adjunctive activities the following: athletics, recreational sports and games, soldier shows, soldier music, theater motion picture programs, library resources, USO shows, Service club programs, arts and crafts, civilian facilities, and Post Exchange activities. Also the Special Service Officer acts a liaison between military personnel, USO groups, and civilian organizations. With these tools in mind, let us analyze these two responsibilities: Special Service or recreational activities, and the Reconditioning Program. The dictionary definition of recreation is "the act of being recreated, refreshment of mind and body after toil; diversion, amusement." A better definition of recreation in my mind is recreation for the re-creation of energy through leisure time activities. The definition of reconditioning is "the act of restoring to proper or normal condition, re-establishment to health" of wounded soldiers, which is exactly what we are trying to do here. Lastly, comparing the two definitions you will find very little difference in their meanings. Special Service and Reconditioning should have about the same goals but with a different approach to their objectives. The Reconditioning Program, of course, is more technical in nature because the work carried on must be highly

supervised with each individual concerned receiving special and private attention. The Reconditioning Program is compulsory while Special Service undertakings are entirely on a voluntary basis. Special Service Officers provide facilities, equipment and set up the organization in relation to the needs of the individual at the post, camp or station of which he is Special Service Officer.

Special Service functions must be in addition to the Reconditioning Program and must supplement it. To do this, the Special Service Officer and the Reconditioning Officer must work in harmony. One must not try to absorb the duties of the other, as is being done in a few of the hospitals I have already visited.

Our programs are similar, our objectives are similar, but we must not let ourselves believe that one program can take the place of the other. One must supplement the other. The Reconditioning Program and the Special Service Office must be organized to fulfill the mission of their command. The Special Service Officer has to plan his work to dovetail into the Reconditioning Program. We remind you again that the Special Service functions must be additional to the reconditioning and other efforts.

Now, let us take each of the Special Service Officer's tools and see how they fit into the program. Take athletics: athletics as a rule is one of the activities the Special Service Officer may have to reckon with. At general hospitals and station hospitals, the Special Service Officer should not have much to do with patients' athletics because the individual needs of the men in your hospitals have to be under the supervision of the medical and reconditioning staffs. We Special Service Officers will aid and assist you but we realize that athletics, as far as the patient is concerned, is extraneous to his field.

Recreational sports and games is also a problem of the Reconditioning Section where patient personnel is involved. It is not part of the Special Service Officer's work in a hospital. Athletic and recreational sports and games precipitate to the Special Service Officer only when he helps to provide for the plans and training of the station complement where he generally provides a fairly well rounded routine for these men. Some of us forget the men who are assisting us in our work, and do not provide enough entertainment and recreational activities for our station complement personnel. We forget about them because of the hours they work, and we do not organize for their relaxation as we should. Soldier shows and soldier music of course should be handled in cooperation with the different service units on your station. Properly, the Special Service Officer should have charge of all soldier shows and soldier music. I believe that it is being done that way, generally. In your soldier show and soldier music, you should not rely upon your station complement for show personnel. Last night's entertainment was a good example when some of the patients took part in the program. It is a very good thing to include those men because it gives them something to do, and the men in the wards seeing one of their buddies taking part in informal activities, such as soldier shows or soldier music, will get greater and more thorough benefit from hospitalization. It is wise to include as many patients in your program as possible. Some hospitals are using patient personnel alone to make up the cast of their shows. Of course the theater motion picture program is working well at most posts. I won't say anything about that. The library: A few words were said about this in a previous talk at this conference when it was said that the library program is not what it should be because sufficient escape literature is not always available. The head librarian of the Ninth Service Command will visit all general hospitals within the next two weeks to coordinate the libraries into the Reconditioning Program. USO shows and service club programs, of course, are part of the Special Service function. They are brought into the hospitals through the Special Service officer and should remain one of his responsibilities. The development of arts and crafts is an entirely new work with the Special Service Division and at the present time is almost universally being conducted by the Red Cross and other services which will probably continue to be responsible. We do not intend to step into the hospitals and attempt to put on an arts and

crafts program, or hobby program. It is being done well now. In some places the Special Services arts and crafts plan is working amiably with the Red Cross and other services, and there is no friction. Civilian groups' assistance is now a very definite part of the Special Service Division work. We are going to different clubs and other units and organizing civilians into recreational groups, giving them some part of the program and making them feel that they are a part of the program and making them feel that they are a part of the team to help win the war. Before we kept them aside and hadn't paid much attention to them, but we are now making the greatest possible use of them in all our work.

Having all this in mind and varying his schedules, the Special Service officer can meet the needs of any individual.

In summary, I would say that to have a successful program you have to have the cooperation of all Service Units. We of the Special Service division will assist you in any way when we are called upon, and if any of you wish any assistance from our Special Service Division, the Special Service Division in Fort Douglas will send an advisor to help you. One other point needs emphasis: do not try to absorb and take over the duties of the Special Service officers in your hospitals. As stated before, it is being done that way in a few places and the Special Service officer is being pushed aside. Your program is large; so ours is large. If one group of men tries to do all the work, none of it will be done correctly. Let us have our program and we will assist you with your program. Thank you.

LT COL JOHN J. LOUTZENHEISER: The next paper this morning will be presented by Colonel Williams, Military Training Division, Ninth Service Command. Colonel Williams.

XVIII. LT COL S. W. WILLIAMS, MC

General McCoach, gentlemen: I was handicapped a little bit in the preparation of these subjects with reference to military training, because I wasn't fully cognizant of the things that already had been done in connection with carrying out military training in the Reconditioning Program. So if you have already accomplished and are already doing all the things that are suggested here, that will be very gratifying.

Since refresher military training is included in the Reconditioning Program, naturally all of us want to accomplish this training in a way that will produce the best results, and that will send the soldier back to duty with added confidence in his ability to do his job. If any of these suggestions will help in accomplishing these results, that will be very gratifying.

1. Military training is not to be considered the primary purpose of the Reconditioning Program. However, refresher training is an important phase of the program as it will enable the soldier to return to duty better prepared to resume his military specialty.

2. The successful accomplishment of refresher military training in the Reconditioning Program challenges the enthusiasm and resourcefulness of each individual who is responsible for conducting this phase of reconditioning. I mention that particularly because many whom you have in this Reconditioning Program will have various levels of training, as well as various levels of intelligence and aptitude. It will not be a simple matter to classify these individuals and fit them into the proper group to accomplish the best results with the least effort.

3. Prior to the assignment of individual patients to this phase of the program, it is suggested that careful training tests be made in order to determine the following:

a. Present general level of training. (The extent of training under an appropriate military training program.)

b. The specific subjects, as outlined in "Reconditioning Program--"Instructor's Guide", Headquarters Ninth Service Command, May 1944, in which the individual is deficient. It is believed that this careful testing procedure would be of material assistance in assigning the individual to proper group or class in the program, and avoid needless waste of time in repetition of subjects in which the soldier is already proficient.

4. While the "Instructor's Guide", mentioned above, includes a comprehensive outline of the most appropriate military subjects which seem practicable to include in the program, it is believed that one other subject, or rather method of conducting refresher training, might well be included. Since the ultimate purpose of the program is to return the soldier to duty as soon as possible, and to prepare him physically and mentally to resume his military specialty, it is recommended that, in so far as practicable, applicatory training in the soldier's military specialty be included in the schedules. This seems particularly desirable in the case of utility specialties, such as plumbers, carpenters, electricians, repairmen and mechanics. It is likewise highly desirable in the case of medical department technicians, radio, teletype, and telegraph operators. You might include the largest group of military specialists, the riflemen. Most soldiers' specialty is to shoot. However, it is not to be inferred that each man is to be assigned to a duty corresponding to his SSN; it does mean opportunity for practicing specialties be arranged if possible.

5. Current Modification Training Programs that pertain to Army Service Forces (I am only familiar with those) do not allot additional time for completion of trainin;under War Department Circular No. 48, 3 February 1944. The Reconditioning Program affords an excellent opportunity for refresher training in accordance with this circular. It is recommended that this training be included in schedules to the extent necessary to insure that individuals attain the minimum standards of proficiency required by paragraph 3 of the circular. Particular emphasis should be placed on the importance of self-aid. In many instances only self-aid may be available. Efficiency in its application requires practice, practice, and more practice.

6. The value of swimming in physical reconditioning and as a recreation can hardly be overestimated. Proficiency in swimming is a highly desirable accomplishment for all members of the armed forces. For those hospitals having swimming pools available or at which they may be made available later, attention is invited to Army Service Forces, Headquarters Ninth Service Command, Circular No. 27, 5 June 1944, which states, "The American Red Cross will assign a national staff man to train instructors in swimmingto any camp desiring such service. Request for this service should be made through the Red Cross Field Director of the camp concerned." In addition to instruction in swimming, life saving measures may well be included. As an outstanding example, a statement made by Captain Bertram Groesbeck, MC, U. S. Navy, in his paper, subject, "The Technique of Self Preservation". The Military Surgeon, Vol. 94, No. 4, April 1944, is quoted. "One of the most spectacular things taught in connection with sea rescue work is the use of the individual's own clothing to maintain flotation. We feel safe in saying that the average individual does not appreciate the value of his own clothing as a life saving measure in the water. When you know how, it is a very simple matter to keep yourself afloat by the use of your own shirt or your trousers." Instruction in life saving measures should follow the showing of TF 1-486, "Swim and Live". Just a word in connection with the use of Training Films. I don't expect to make any new suggestions. I am sure you are all familiar with them. However, the use of training films is sometimes misunderstood, and probably they are many times improperly used. A Training Film is not an end within itself; it is a training aid pure and simple and should be used in connection with applicable practical training on the subject. Interest in swimming might be stimulated by inviting professionals or local amateur experts to put on an aquatic program. When they brought me down last night they informed me, without questioning on my part, that this had already been done at this hospital.

7. Chemical Warfare training, particularly in recognition of gases and first aid treatment of gas casualties, requires frequent repetition. With that, I am sure we will all agree. In this connection, attention is invited to War Department Circular No. 36, 1944, which makes certain changes in terminology pertaining to chemical warfare.

8. In connection with subject, "U. S. Army Rifle," which is found on page 12, "Ninth Service Command Instructor's Guide," attention is invited to paragraph 1, Part 2, ASF Circular No. 108, 20 April 1944, which states that "Military training equipment in the category of arms or combat weapons will not be stored or used upon or within the hospital proper." It is apparent that such equipment may be used in refresher military training of classes one and two, only. The issue of certain type rifles and machine guns for this purpose has been authorized.

9. Map reading is mentioned in order to stress its importance. Available information indicates that in many instances, troops have shown a lack of adequate training in this subject. Frequent refresher training is necessary to maintain a high standard of efficiency.

10. It is urgently recommended that full use be made of training aids listed in Field Manual 21-8, 14 February 1944, as supplemented by paragraph 6 and changed by paragraph 8, Training Circular No. 36, 17 May 1944. Additional information concerning commercial sources of models of vehicles, tanks, guns, aircraft, etc., may be found in paragraph V, Army Service Forces, Headquarters Ninth Service Command, Circular No. 27,5 June 1944. I mention this particularly as it will be an aid to you in selecting and procuring certain of these training aids which are listed FM 21-8. Also, the above-mentioned manual shows several training devices which may be constructed locally. Such construction is recommended as it serves the dual purpose of manual and military training, as well as the use later in military training.

11. Finally, schedules should be prepared that will insure continuity of subject matter and progressive training and, at the same time, avoid monotonous repetition. If progressive refresher training schedules are followed, it is believed that progressive physical reconditioning will be facilitated.

LT COL JOHN J. LOUTZENHEISER: The next paper will be presented by Captain Thomas E. Barrett, Director of Reconditioning Program, Bushnell General Hospital.

XIX. CAPTAIN THOMAS E. BARRETT, MC

General McCoach, General Willis, General Hillman, fellow officers, ladies and gentlemen:

I will have to apologize, for after I heard yesterday's papers, I felt that in talking on the Reconditioning Program in a general hospital, I had omitted some things so I sat down and re-wrote my paper to cover those points.

The successful conduct of a Reconditioning Program is based on a clear understanding of its aims and objectives, and how you are going to achieve them. That "how you are going to achieve them" is a very important item. As a medical officer you must know what that objective is, how you plan to reach it, how you plan to convey the idea to the men you are going to do it for and the men you are going to do it with.

The members of your organization must understand the program and know their part in it if it is to be successfully carried out. This means that the director of reconditioning must, beforehand, draw up the plan of organization and the distribution of his personnel, and know how he intends to reach all his patients. At the same time he

must instruct all of the men who will be available for the work before he begins. The next step is to survey the character of the patients who are going to be available for the program, and then plan your classification of these patients; and finally, conclude a tentative schedule for each phase of your activities. In a general hospital we have to deal with all kinds of patients. Therefore these schedules must be flexible, to reach all physical, mental and educational levels. When this has been done, the plan can be put into operation. This may be done in various ways. I shall state only one which has been helpful to me. When I explained all the fundamental details to each man entering our program, both patients and those who were going to work with me, we had better cooperation, and the program ran along more easily and with fewer difficulties. This is the way in which our program is run: each man understands his own duties and can explain them to the ward officers himself and to the Medical Administrative officers assigned to the Medical, Surgical, and NP Services.

Patients, as we all know, are divided into two arbitrary classifications: the advanced unit and the hospital unit. Now, as medical officers, we don't try to categorize different diseases. We make this an individual classification, depending not upon diseases but upon limitations. Some times we have two or three classes in one unit. At other times we have Class IV divided into three or four parts. It all depends upon the specialties we are dealing with.

The advanced reconditioning unit is divided into two main classes. This is an arbitrary division, which we modify according to the demands of the patients. Class I: Patients capable of carrying a full, vigorous military program will be returned to duty. Class II is arbitrarily divided into Classes A and B. 'A' consists of those patients who are able to go through a physical training program, but are injured either due to combat or disease; however, we are able to return them to some form of limited duty. Now this class may again be divided, dependent upon the census of the patients. Class IIB patients are those patients who are able to carry on a modified physical program, but will be given a CDD. These men are trained separately from the other two groups. Mild neuropsychiatrics are scattered through the whole unit. I have not found this to be injurious to them. In December, 1943, 140 patients were sent to me at one time. Of those 140 there were 40 NP patients, graded from moderately severe to severe. After watching them for one week I found most of them to be of the anxiety type, which my psychiatrist confirmed for me. Also we found four mild psychotics among the group. These were immediately transferred out. This large group was put into advanced reconditioning after screening, and by the end of last month those 40 NP patients were returned to full duty and many of those had themselves asked to be returned.

The patients assigned to the advanced reconditioning unit are completely divorced from the hospital. They are treated as soldiers on duty, with all the privileges of men on duty. They are assigned to regular duties and we are extremely careful to assign them according to rank. This is a point we have found to be very important, because these boys are extremely conscious of their rank and if we recognize it they will go all out to help us.

In the advanced reconditioning division I have established a first aid station and examining room, not to invite casualties, but as a room where medical officers and the P.T.I. officer may come to examine the patients in groups and compare their physical progress with their clinical records. Through this examination we get criticism, both constructive and helpful, by their offers of suggestions concerning the progress of the patients.

The hospital division is likewise divided into two classes those patients who require closer clinical observation or specialized treatment but are able to go to the patients' mess; and those who must remain on the ward.

Class IV patients are subdivided into two groups. Bear in mind

that these are frequently subdivided further dependent upon the patients themselves and their condition. The two sub-classes are 4a, semi-ambulant who can be up and about the ward, but eat on their own ward and require various treatments through the day which the ward officers performs for them. The 4b patients are strictly bed cases, which are not critically or seriously ill. It is quite obvious that for the seriously or critically ill the treatment is absolute rest.

These are the main units. Now the underlying plan of the program for the two main divisions is: The advanced reconditioning unit's program is primarily that of physical training with the educational program being secondary. In the hospital unit the educational program is primary with the physical program being secondary. The secondary part of this program is not neglected. It merely is arranged to fit the physical condition of the patient.

The duty officers and enlisted personnel are assigned to their jobs in this program in such a way that they understand what the aims of the program are, what their specific duties are, and what the other men in the program are doing and how they plan to do it. The success of this program depends upon how well the organization understands what we are trying to do and how we are doing it. We get much better cooperation and a more actively moving program by the mere fact that these men know as much as I do about it, and many times, more than I.

Hospital units function more smoothly by developing specialists. Here, one officer is assigned to coordinate the educational program. The other educational officer is assigned to coordinate the physical program. We have two physical training instructors detailed to Class IV. These men have qualifications primarily for PT and PTI. They have worked with the patients for almost a year now and have been handling bed cases. The other four PTI officers coordinate and control the athletic, physical and educational program under the direction of the two educational officers.

Now it is impossible to have enough specially trained men either among the duty personnel or patients who can keep certain fundamental diversified vocational or educational programs running at all times. It is true that the Occupational Therapy Department can handle the precription work, but that does not relieve the bulk demand from the larger group of patients who do not require special prescription occupational therapy. This can be overcome in many ways, and the way in which we have done this is through contacts with the State educational units. Through them I was able to have four full time civilian vocational teachers of college grade assigned to our hospital five days a week. These men teach mechanical drawing, handicrafts (which includes leathercraft, metal craft, jewelry designing and hardwood carving), radio (basic and advanced) and woodcrafts (cabinet making, pattern making and general construction), without any cost to the Army or the hospital. Many states have such a set-up. Utah has one, California has another. It makes available to you many sources of help. In addition to that, the director of reconditioning must act in such a way as to keep in contact with various patriotic groups. I have found that various patriotic associations - such as the Kiwanis - will furnish much material to operate these programs if you let them know in what specific ways they can help out. In fact they are usually glad to give, but don't know where or how to give. I have been given a complete printing press with all its accessories, by merely giving a dinner talk before a large group of businessmen that did not even want its name used; at the same time this group contributed a linotype which is now used in our vocational set-up. We have found several linotype operators, two to act as instructors, and we are going to set up this training in the occupational therapy department. The director of reconditioning must put in a lot of extra time and contact civilian groups. It adds to the success of your program and also promotes a cooperative relationship between the military and civilian groups.

Now, also, in trying to overcome any difficulties that will arise, the Reconditioning Program as I look at it is not an individual's job--it is the job of all. To gain complete cooperation from the professional

services, they must be made part of the program. This cooperation can be had if they understand all about your program, and know that the Reconditioning Program is so planned as to fit their services. I have set up what I call an Advisory Counselling Board composed of the Chiefs of the Medical, Surgical, and NP Services, the officers in charge of PT and OT, the Commanding Officer of the Detachment of Advanced Reconditioning, and my two educational officers, with our commanding officer as chairman. This group meets once a month, and at these meetings suggestions and criticisms are offered. This coordinates the Reconditioning Program with the functions of the hospital, and brings these men into active participation. Visiting the ward officers, making rounds at different times, and going over the cases, makes the ward officer feel he is taking just as active a part in the program. It is planned that this Advisory Counsel which I have just mentioned will meet once a month to coordinate the Reconditioning Program with functions of the hospital, for after all, the general hospital is a place where the man is sent to be brought back to health and returned to duty or to civilian life in the best possible physical condition.

Finally, the way in which we keep records: I have assigned one of the enlisted men from the reconditioning center to act with one of the patients to compile and file records on all our activities. This is done in the following manner: We obtain a list of all patients admitted for the past twenty-four hours--their name, rank, diagnosis and the ward and section to which they were assigned. We then send out a confidential questionnaire to the medical officer, another to the patient. The patient's questionnaire gives all the information regarding his likes, dislikes, hobbies, trades, etc. The medical officer's report pertains to the patient's medical condition, to what class he may be assigned, and his probable disposition. We collect these questionnaires ourselves and bring them back within a period of 24 to 36 hours. We then pick him up on our records and he is assigned to some part of our program, provided he is not critically or seriously ill.

This brings something very striking to my mind. We are dealing with a democratic soldier, who was brought up, to the age of eighteen, in a country where he can think and do most of the things he likes; I have found that by continuing to treat him in that way, we do not have to force him into the program, but he will voluntarily come in himself on his own desire and not through anything we may say. We wait a week and sometimes two weeks, and at the end of two weeks I can safely say that 75 per cent of the group are taking part in the program voluntarily. After all, the other 25 per cent can be found in any cross section of civilian life. I also let them know that the questionnaire we sent out is strictly confidential and only for the use of recreation and classification officers. We would like to follow that plan as closely as possible and keep strict confidence with the patient.

Now then there are certain internists who will always disagree. I handle malaria patients a little differently from those handled here. I look upon malaria as just another condition. If not complicated, the patient can take full active part in the program.

This is a brief sketch of the way we are running our program. I thank you very much.

LT COL JOHN J. LOUTZENHEISER: The next paper will be presented by Miss Steinmesch, Occupational Therapy Consultant, Reconditioning Service, Ninth Service Command.

XX. MISS HULDAH ANN STEINMESCH
OTA, Reconditioning Service

The words occupation and therapy I need not define to this group, but I wonder if you have any idea just how many people, professional as well as the layman, see the occupational therapy aide on the wards in the hospital and in the shops and see no more than that the aide is supplying the patient with materials and showing him how to make an interesting finished article. Killing time!

How blind they are! They do not see that the goal of all treatment is the resumption of all the functions of both body and mind, that activity, movement and changes are fundamental processes necessary to normal physical and mental health. Movement is life. Work is associated in our minds with health.

This is where the O. T. comes into the picture. The patient has recovered from the shock of surgery, from the acute period of his illness, and is feeling that maybe he will live through the whole thing. With the permission of the officer in charge (this may be secured either by blanket lists of groups 3 and 4 patients from the Reconditioning Section, or by individual prescription, with some notation on the limitations of the patient) it is now time for the O. T. to interview the patient to find out what his interests are, some of his background, and to plan some activity with him, either diversional or remedial. With patients who have courage and mental resources, this is not a problem, but there are patients who lose all desire to, or refuse to face the responsibility of living in a competitive world--the escapist. Here the O. T. is challenged to sell the idea to the patient, which is sometimes rather difficult as I know from experience. The soldier who has been in battle may not care for what we have to offer for bed patients. As a rule by working with the patients who are interested and thereby expose other patients it is possible they too will catch the disease, and surprisingly enough, they may become our most enthusiastic workers. We do not always succeed, neither does the MD cure or relieve every case -- but if the patient load is not too great and the therapist can take the time, she will be able to accomplish some rather amazing results in change of attitude.

Now that we have the patient "conditioned" to receive therapy aid, i.e. —informed of the part that this service plays, etc.-the O.T. aide assembles the necessary equipment and supplies and devises such techniques as may apply to this particular case. Perhaps you noted that knot tying activity in Ward B-14. We want to bring out the fact that this is excellent and the patient received beneficial exercise by using his hands.

Further, cord knotting may be used for traction patients; the benefits that may be derived include use of upper extremities; chest expansion; and maintenance of muscle tone. This exercise accustoms patients to the use of crutches to the extent that even patients themselves have noted and commented about this; it keeps patients awake during day; it controls activity and makes for less drug use and better appetite and better sleep. If it is a hobby or diversional case (this is not a good term, for there is real treatment value in doing something just for the fun of it, and the best results are obtained in remedial work when this same happy choice of activity is possible and students or trained personnel or volunteers, (Red Cross Arts and Skills Units where they are available) are used, the O. T. aide is wise to supervise and direct their handling of the case while she clears more patients and does the remedial work. This enables your trained staff to cover more territory; and in the special centers for the blind, hard of hearing, amputations, and the others they will have additional specialized treatments to give.

Best results may be obtained in this phase of the program if the treatment schedule of the patient has been carefully planned by the medical officer and the aide. Where physical therapy and occupational therapy are both indicated, the greatest of care must be observed so that there is no duplication of specific motions, an overlapping which

might result in overdosage and excess fatigue. There are, of course, certain instances where this duplication is to be desired, but the departments involved in this treatment schedule must be coordinated in order that they do not work at cross purposes. In plastic surgery we have had to watch this very carefully. I think you will understand how necessary this is. Here the processes involved and their value to the patient are all important and the completed article, except for a satisfactory result, is at a minimum. Let me not give the idea that an unsightly article or poorly working product is to be desired--no, such is not the case--for unless the article or activity has some attractive or pleasing feature, it is not likely that there'll be any selling point to induce the patient to exert himself. It is important that the therapist make a notation on the record of each patient of progress made. We do not stress the finished article but stress what it does for the patient and why that particular art or craft was recommended.

As these patients are seen from day to day by the aide, not only should instruction be given but progress noted, special skills and interests recorded, and the activity stepped up as the patient is equal to it--changed if necessary.

As the patient moves from Group IV to Group III, the O. T. aide should inform the patient of his transfer to shop activities and introduce him, if at all possible, to his new situation and new aide. This encourages the patient in his new surroundings and tends to give him the feeling that his Army is a pretty fine organization. Considerate handling of the patient while in the hospital may be the deciding factor in his desire to return to duty.

By this time some decision has been made as to disposition of the patient, and the O. T. should be guided by this in her advising the patient as to his choice of activity. As the whole Reconditioning Program is planned toward speeding up the process of returning men to duty and in a better condition, she should not lose sight of this objective. Should the patient be scheduled for a CDD and the nature of his disability requires a change of occupation, now is the time for the O. T. to acquaint the patient with such pre-vocational activities as her department has to offer and perhaps let him try his hand at two or three so that he may see what his limitations are and what particular skills he has to offer to a new occupation. This is particularly true in amputation and the blind group. This "trying out period" while still in the hospital can help many men make a satisfactory adjustment both mentally and physically and, in some instances, indicate what future training will be necessary in order for them to fit into civilian life. I believe that the findings of the O. T. aide along this line should be incorporated into the final history of the patient and the recommendations sent to such agencies as will handle his case upon his separation from the service. This is not a rehabilitation measure but a guide post--a leading of the way. With the possibility of training centers, this part of the program can be developed to a high level and valuable time and money saved.

It must be remembered, and I believe that the demonstration here at Hammond has brought this out, that the O. T. is concerned with the mental, physical, social, and economic effects of their treatment program on the patient, as a part of the Reconditioning Program and that as the patient recovers, so must the dosage be increased. A good Occupational Therapy Department has much to offer the whole hospital. Thank you.

LT COL JOHN J. LOUTZENHEISER: The next paper will be presented by Captain James W. Layman, Director of Reconditioning Division, Hammond General Hospital. While Captain Layman is coming up, I would like to make some announcements. The groups for this morning's tour of the Advanced Reconditioning Section will be the same as yesterday. Transportation will be provided to take the delegates down through the section. The panel session that is on the program for A-10 will be held in this hall. This will be a meeting for the commanding officers and chiefs of the Reconditioning Division, with members of the SGO and Ninth Service Command, of course.

XXI. CAPTAIN JAMES W. LAYMAN, AGD
Director, Reconditioning Division

General McCoach, General Hillman, General Willis, members of the conference:

I find myself being repetitious and feel that Captain Barrett and I should have gotten together before our papers were presented. However, I have tried to approach the problem from a somewhat different angle, that is, to outline what might be called the chronological and logical steps in developing a Reconditioning Program in a general hospital.

The operation of a Reconditioning Program reduces to two essentials: (1) the objectives laid down by the Surgeon General and, (2) the accomplishment of the mission at the local level. The latter is determined and affected by many factors, such as personnel available, type and range of patients primarily served by the hospital, average length of patient care, and physical facilities available.

At the local level, the first problems to be solved center in both a clarification and determination of the roles and responsibilities of the agencies which must cooperate in Reconditioning activities. As has been remarked frequently during the conference, the medical staffs maintain responsibility for defining the medical classifications of the patients and the limits within which those actively engaged in the Reconditioning Program may function. Only when the medical staff has established uniform definitions of the patient groups and the permitted or desired activities, is it possible to carry out Reconditioning functions. Otherwise, such activities as calisthenics must be adapted to each individual medical officer's definition of the patient class and the type of activity he permits. Finally, unless the medical staff assumes this responsibility, judgment rests with a staff which may not always be sufficiently competent to decide, particularly with medical and surgical problem cases.

Similarly, it is clearly necessary to define the areas in which other Army and civil agencies will participate and the responsibilities of each. Unless this is accomplished, confusion as to scheduling, initiation and maintenance of programs and determination of who is to do what results. This can only produce a tendency for each agency to do either what it wants to do or what it thinks it can do, thereby leading both to unnecessary duplication of some activities and neglect of others. For example, regulations state that Special Services are responsible for "athletics." If so, does this mean, for instance, that Special Services will administer the gymnasium program where special apparatus is being utilized on specific types of cases. If this is marked as a function for Special Services, the medical staff must then exercise control over both the Reconditioning Division proper and those activities carried out by Special Services which peculiarly relate to reconditioning.

The next step in organization involves the selection and training of key personnel. That is, every phase of activity subsumed under Reconditioning demands considerable degrees of training and specialization. For example, we have noted a great difference between attitudes and results obtained from patients exercised by untrained ward masters, or others, and those exercised by qualified instructors. Similarly, guidance in the selection of educational courses is more than a matter of opening the USAFI catalog. In other words, it must be done by competent persons who know how to evaluate such factors as previous educational levels, general intelligence, aptitudes, skills and physical condition. This latter is particularly important where it may play a vital role in either military or post-war civil occupations.

A correlated point with reference to key personnel is a recognition of the number required. If the staff is held at a low level it becomes obvious that most, or a large share, of its time must be devoted to training and supervising a constantly rotating personnel in terms of patients or others used in the program. This, of course, has many

practical disadvantages, such as not having instructors with the necessary background available at the time they are needed. Or, if ward masters are relied upon too extensively, the Reconditioning Program will suffer during those periods when either the hospital or particular wards are filled to capacity. In this connection, it is also true that many ward masters lack the interest and backgrounds necessary for many reconditioning activities.

However, it should be emphasized that even with a full T/O, as laid down by directives, it is both desirable and good program planning to utilize qualified patient personnel wherever possible. In some instances, this enables expansion of activities which otherwise would not be possible. In others, it permits the scheduling of some activities of a unique and challenging nature. This is particularly true in the orientation-education activities. That is, certain patients, with guidance and assistance in methods of presentation, can give first hand information relative to many orientation objectives. Others can be drafted to serve as instructors for bedside teaching and group classes. Hence the Forms 20 and 66-1 should be studied constantly and used as a basis for establishing a "rare-bird" file.

Once both the medical and reconditioning staff have reached a mutual understanding, objectives and responsibilities have been clarified, the actual planning and scheduling of the activities can occur. In every instance, these must be integrated into the basic hospital routine. That is, each activity must not only be considered in its relationship to reconditioning but also with reference to what the patient must be doing from a strictly medical viewpoint. For example, calisthenics on a surgical ward must be planned for some time other than when dressings are normally being changed.

Such scheduling becomes a complicated procedure when all of the participating agencies are considered. For instance, the Red Cross at this hospital conducts an extensive recreational program of movies, games, and parties. Similarly, Special Services conduct its USO shows and other activities. Unless these are properly scheduled, patient participation in each is determined more by the sales appeal offered by the responsible organization rather than the enduring and fundamental values offered by the "competing" organizations.

In summary, the success of a Reconditioning Program is determined by the intelligent understanding of all concerned, adequate and trained personnel supplemented by patients and others who may be utilized, and proper integration of correlated activities into basic medical schedules.

LT COL JOHN J. LOUTZENHEISER: The groups will form as they did yesterday to visit the Advanced Reconditioning Section and malaria ward. Conference group and panel discussion will be held in this hall at 1 P. M.

END OF MORNING SESSION

BRIGADIER GENERAL J. M. WILLIS: While we are waiting for General Hillman, we will hear from Chaplain Blakeney:

XXII. COLONEL J. I. BLAKENEY
Chief Chaplain
Headquarters Ninth Service Command

Gentlemen: It is a pleasure to be with you in this conference. I have enjoyed every bit of it, and you have taught me a good many things. I don't think I can teach you much that you don't already know. It reminds me of a story that was told me last year in London: Gracie Fields was in an air-raid shelter, which was very dark, when a man kissed her. She said "Irving, you shouldn't have done that in a crowded place." He said, "I didn't do that - it must have been somebody else who did it. I'd like to teach him something." Gracie said - "Irvie, you can't teach that fellow anything."

This has been a very fine thing, for me and the other Chaplains to listen in on the things that have been given. One thing I appreciated very much was the fact that something has been said by several gentlemen on the program regarding the spiritual values in the work of getting our men in the attitude of wanting to get back into line again and do full duty either as soldiers or citizens. I believe, and I think that most chaplains agree with me, that the chaplains can help greatly in this. My plea to you this afternoon is: use your chaplains to a greater extent than they have been used in this work.

I am not going into detail as to how this should be done. Next week I am going to pass out to the chaplains in this Service Command a little pamphlet telling how to start on that. With your cooperation, I believe that you will find wonderful outlets for the work they can do for you, and if they do not cooperate with you, just let us know. I think most of them are willing, and when they find out what you want I think they will give you fullest cooperation. Spiritual values will help you build up a good morale. As the Commanding General has told us from time to time, good morale is built on a religious foundation. I'm not saying you have to be good religious men, and no good chaplain is going to tell the men they must believe as he does. All we ask for is faith. By faith we mean having faith in a Supreme Being, then exercising that faith. Faith in our country and faith in ourselves will help us to build the kind of men you need, and to rebuild the men under this program.

Next week we are sending these pamphlets out to all of our chaplains. We have been working on this for some time. It includes suggestions to the chaplains for one thing, and then we have the foreword by our Commanding General and General Willis, as well. I am sure the chaplains will find something of interest here. Use your Chaplain's! Use them to help get these men into the notion that they are still worth something. One thing we have found in going into hospitals is that once in a while a man says: "I'm through. I'm not worth anything to anybody. I might as well be dead." That isn't true. Most of you medical men know that. These men can be useful citizens, and perhaps useful soldiers. It has been my pleasure to serve in a general hospital. I remember going into a ward one time and a man was just brought in terribly injured. "I don't need you", he said. I replied, "I didn't come here to poke religion down your throat. We are here to help you. We have the best nurses, the best doctors, the best facilities, and we want to help you get in good condition as soon as possible." He changed his tone, and before he left that hospital he was in good condition, and he was one of the best friends I had. Not only that, but he came to church afterwards. That, of course, is part of our ultimate aim. Chaplains want to serve you. Cooperate with them, and I am sure we will get along fine together and do the job which we have before us.

Thank you very much for the pleasure of being with you in this conference.

MAJOR PATRICK: Rarely have we had the opportunity to have so many persons, distinguished and specialized, whom we can ask questions. You have written these down. We will read the questions; then ask some member of the panel to discuss it. Obviously since the room is large and quite well filled, we will have to be reasonably quiet in order to hear the speaker.

The panel consists of:

Major James R. Patrick, A.G.D., Deputy Director, Reconditioning Service, HNSC, presiding.

Discussion Leaders:

Brigadier General C. C. Hillman, Surgeon General's Office.
Brigadier General J. M. Willis, Service Command Surgeon, HNSC.
Colonel Augustus Thorndike, M. C., Surgeon General's Office.
Colonel J. L. Blakeney, Chaplain's Corps, HNSC.
Lt Col John J. Loutzenheiser, M. C., Director, Reconditioning Service, Orthopedic Consultant, HNSC.
Major Arthur A. Esslinger, AUS, Surgeon General's Office
Lt Col S. W. Williams, Military Training Division, HNSC
Major Walter E. Barton, M. C., Surgeon General's Office.
Major William S. Briscoe, A.U.S., Surgeon General's Office.
Major George H. Ivins, Director, Morale Services Division, HNSC.

The first question posed for this expert council is, "How can we have patients in the Army Ground Forces released for us in Reconditioning?" The question goes on and says, "We have requested that several individuals be sent into our Reconditioning Program, but each one has been disapproved by General McNair." As you know, there are two categories in which they are reported to the Ninth Service Command: In the hospitals, the battle wounded, enlisted personnel, are reported to the Ninth Service Command, then sent to the Reception Center; from there they are reported to The Adjutant General's Office and from there assigned to the Ground or the Air Forces. If the man happens to be an Army Service Forces man, we have a fair chance of getting him for you. If he happens to be a Ground Force man, our Headquarters has to have the concurrence of the Ground Forces Commanding General in Washington, or Air Forces likewise. I believe Colonel Thorndike has some recent information on that point. I'll ask him to answer that for you.

COLONEL THORNDIKE: It might interest you to know that the Sixth Service Command (Percy Jones General Hospital), as I mentioned in my paper yesterday, has been successful in transferring such patient personnel, limited duty status, to their own detachment for the Reconditioning Program. The patient himself initiated the request; he was limited duty and had the qualifications. The request went through the Commanding Officer of the hospital, through the Service Command, through the Ground Forces commander and was cleared by The Adjutant General, and they have not had a refusal since this was inaugurated. I believe it is a new policy, though, and I am hesitant to inquire too much for fear we might lose opportunities to secure some of this limited duty personnel for duty in the service forces.

MAJOR PATRICK: Thank you Colonel Thorndike. The next question posed is the question regarding the advised average length of recumbency for hernias, also, "Where are Dr. Power's figures available?" We'll ask General Hillman to answer that question.

GENERAL HILLMAN: The matter of handling hernia has been of special consideration on the part of the Surgeon General. Some months ago, in fact a year ago, I would say, it was found in certain hospitals

that hernias were being gotten out of bed earlier and being treated according to Dr. Powers' ideas. As you all know, our Surgeon General is a highly skilled surgeon and has very definite ideas on this subject; he has directed that a directive be prepared and published which would set forth the prevailing ideas, and I think this prevails generally in surgery relative to the treatment of hernia. This directive is still in existence. A Surgeon General's circular letter prescribes that hernias shall be kept in bed for a minimum period of two weeks and that they shall not be returned to full duty status in less than two months; that is the policy that is in existence at the present time, and which it is desired be followed out. Major Esslinger referred yesterday to the studies of Dr. Powers in regard to the early physical exercise in convalescence following surgical operations, but that was only quoted or cited by Major Esslinger as a trend and it is not intended at all that it be used or cited as a guide for getting people out of bed earlier than general surgical opinion now dictates. I think we should be very careful in setting up Reconditioning Programs that we not appear to attempt to set a policy for the surgeons. That is something that the surgeons and the surgical division of The Surgeon General's Office should handle and it is not intended at all to suggest here that there is any change in policy.

MAJOR PATRICK: Thank you General Hillman. The next question has been one that has given Ninth Service Command Headquarters and Washington also a bit of thought, and that is the problem of obtaining weapons--rifles in particular--for men in advance training sections. It is the opinion of this panel that this problem is about to be settled and that a policy ruling will be obtained. We will ask Major Barton to comment on the question of how we can get rifles and similar equipment for the training program.

MAJOR BARTON: General hospitals have been authorized the following weapons: 100 rifles; one light machine gun; one heavy machine gun; five automatic rifles; and one carbine. These are for teaching purposes and need not be in serviceable condition. They are obtained on requisition through the usual Ordnance channels. They, in turn, secure our concurrence, and the weapons are issued providing the terms of Army Service Forces Circular 108 are complied with. They are ordered in the name of the Ordnance Officer, and not by the hospital or by a medical officer. You must indicate in your requisition where the weapons are to be stored. They are not to be stored in the hospital proper. You must indicate the place where they will be stored.

MAJOR PATRICK: Thank you Major Barton. The next question asked is, "How should the medical chart of patients sent to the Advanced Reconditioning Section be handled? Should it be sent to the Section or kept in the hospital proper?" We will ask Colonel Loutzenheiser to comment on that for you.

COLONEL LOUTZENHEISER: This question appears to be a command function. My opinion is that the records are best kept in the Advanced Reconditioning Section when that section is placed away from the hospital area. They should be kept under lock as they are within the hospital.

MAJOR PATRICK: This next question is likewise for Colonel Loutzenheiser. "What progress notes should be regarded as minimal for patients in the Advanced Reconditioning Section?"

COLONEL LOUTZENHEISER: The question of progress notes and other records is one that has arisen many times. Directives state that records should be kept at a minimum in the Reconditioning Program, in order that we will not be using up personnel in keeping records. Some records are necessary in the Advanced Reconditioning Section where the trainees are kept in companies. Company records would appear to be necessary. New forms of many styles should be discouraged. Officers who are interested in certain statistical studies and information, (and we are interested in obtaining that from them), should devise certain record studies of their own so that this information can be obtained. Progress notes should simply state, I think, that the man is progressing

properly from group to group; whether or not his disability is increasing or decreasing; whether he is progressing from one class to another, and whether he should finally be discharged. I do not think that any further comment is necessary on that question. I do believe that personnel other than medical should be privileged to produce some records that can be put on the chart in recording the patient's progress in the Advanced Reconditioning Section. The observer out in the recreation field often learns far more than the medical officer. That is the reason for the Reconditioning Program. You must remember that the patient can always present himself as a patient while in the hospital, but out in the Advanced Reconditioning Section, he will present himself as a soldier and as he becomes interested in the sports he will soon be found to lose many of the disabilities he portrayed in the hospital.

MAJOR PATRICK: Thank you Colonel Loutzenheiser. The next question posed for the panel is, "How are patients discharged from the Advanced Reconditioning Section back to duty? Is the Disposition Board held at the end of the period in the hospital proper? Are any special records employed to effect the discharge of the patient from the Advanced Section?"

Regulations have long since provided for the discharge of patients from general hospitals. By and large, then, the men who are serving under this present or war emergency who are discharged from the hospital come under the regular regulations. There is one exception, however, and that is your battle casualty enlisted man, and also your battle casualty officer, covered by ASF Circular 114 and subsequent WD Directive 212 for enlisted man and WD Circular 161 for officers. In that case we have a standard operating procedure put out over General McCoach's signature personally, telling you how to report those men for assignment, both enlisted men and officers. So, make a note of the letter of the 7th of May on Standard Operating Procedure covering ASF Circular114 and Standard Operating Procedure covering WD Circular 161. You will find that those men, battle casualty enlisted men, are supposed to be reported immediately; they are likewise to be interviewed and it is to be determined, if battle wounded, whether they wish to stay in. If any of you have any difficulty in tying up that Standard Operating Procedure with the ASF Circular 114, we will be glad to clarify it, but if you have read those directives I think you will find such men are reported to the Classification and Assignment Branch in the Military Personnel Division, Headquarters, NSC, and then that Branch authorizes you what to do with them.*

Now then, as to the Disposition Board, it seems that that is a local command function as to when you want to hold the board to appraise these men from a point of view of discharge. General Willis, do you want to comment on that question?

GENERAL WILLIS: I should think that it was a matter entirely of local administration when the local commanding officer wants it.

MAJOR PATRICK: The next question is, "What is the policy concerning assignments of patients to specific activities within the hospital? What type of patients may be so assigned?" The committee had a little difficulty in determining just what that question meant. I will read it again. "What is the policy concerning assignment of patients to specific activities within the hospital?" You see, we have a technical term regarding assignment and evidently you have reference here to a specific duty, for instance, assigning a man to a specific duty or something of that kind. I will ask Colonel Thorndike to comment on that.

COLONEL THORNDIKE: Will the officer who wrote that question explain it a little more in detail. Does he mean assignment to a work therapy project within the Reconditioning Program? Is he here?

COLONEL MCKIE: Since that question was written, it has been partially answered by Colonel Williams. He said it is particularly desirable to

*Since the conference, ASF Cir 175 has been published: This also concerns battle-wounded casualties.

give applicable training in a man's specialty within the hospital, in utility trades such as medical technician, radio men, etc., and put them on those specific duties within the hospital rather than in an overall program. It is also referred to in the article published in the AMA Journal by one of the officers of the Surgeon General's Office in the Reconditioning Division.

COLONEL THORNDIKE: That is particularly applicable to station hospitals where they have training centers right at the station hospitals, or at that same station, such as Signal Corps, etc. They can continue their training while in the hospital as part of their educational and reconditioning. To assign them to other tasks, and have work therapy as part of occupational therapy--(for example, for shoulder and elbow cases, painting might be a desirable type of work)--you didn't infer that interpretation, Colonel?

COLONEL MCKIE: No.

MAJOR PATRICK: Are there any plans for unifying the sources of supply for reconditioning, now $100 per year per bed strength for occupational therapy? Major Barton will answer that.

MAJOR BARTON: The present plan is not $100 per year per bed strength for occupational therapy, but there is a special list of occupational therapy equipment authorized for named general hospitals. That equipment may be ordered through the medical supply depot. Each hospital also has an allotment of cash set up for expendable materials which they may purchase any way they may choose through local channels. There is a planned revision of the present occupational therapy equipment that is now in progress. The equipment list will be greatly amplified, designed to meet the expanded needs of reconditioning and also money allotments covering expendable materials will be greatly increased over what is allowed at the present time.

MAJOR PATRICK: Major Barton may as well answer the next question. "Much inertia is developed by patients, especially the NP patient during prolonged hospitalization overseas and a protracted transport voyage. In a debarkation hospital such as Letterman, this inertia is especially noticeable. What is being accomplished by the Reconditioning Program in preventing the development of the original inertia arising overseas and its further growth aboard the transport?"

MAJOR BARTON: The question in its scope covers the entire program of the NP management. I don't want to go into that other than to hit the high spots. The movement of psychiatrists into the division was predicated on the basis of early treatment of nervous conditions in an attempt to prevent psychiatric casualties. Then the very real increased importance given to rapid treatment of early cases by sedation, returned to duty 60 to 80 per cent of the men right in the combat zone without evacuation. Next there was the introduction of intravenous sodium pentothal as a means of hypno-narco therapy for a patient with emotional disturbance arising out of the war. That, too, has been successful in reported instances, returning 72 per cent of the patients who have reached that point back into some classified assignment in the theatre of operations. There is a very active NP program in the hospitals in the European theatre and in other theatres as well. On the transports, I am sorry to say, the chief job is to get the NP back here safely and quickly and the kind and quality of treatment varies as widely as one could possibly imagine. Some transports have very poor treatment and very poor management and others reasonably enlightened management. Very little in the way of reconditioning is possible and practically none is being done on the transport.

MAJOR PATRICK: Thank you Major Barton. The next question is, "How do we reconcile reconditioning with recent directives to report officers for limited duty while still convalescing and who will even be under

certain type of treatment, during certain duty. That is referred to in WD Circular 161, and paragraph 3 of that circular answers this question. It says definitely that if you need an officer in the hospital to assist in your Reconditioning Program you don't have to put him on detached service to some other station. If you don't need him there and the treatment is going to be for three months or more, and he does not have to see the doctor every day, then you can put him on detached service in order to utilize his services.

The next question is, "In a station hospital serving combat troops who suffer by loss of training in their units when hospitalized, is it more important that they be returned to duty as soon as possible or should a definite period of convalescence be required?" General Hillman will answer this for us.

GENERAL HILLMAN: It is not intended to hold patients in the hospital for a moment longer than is necessary for them to recover. In other words, it is not intended at all that any specified period of convalescence shall be required. It is all a medical matter and the man should be returned to duty at the earliest possible date. In many cases not even going to the Advanced Reconditioning Unit.

MAJOR PATRICK: We will ask General Hillman to answer the next question for you. "In units about to leave for overseas with soldiers in the hospital who have recovered from their acute illness, but have not been through reconditioning, is it more important that such soldiers with 1--2 years training be lost to their organization by retaining these soldiers in a prescribed convalescent program or shall they be returned to their outfits with recommendation as to type of duties they shall perform?" We will ask General Hillman to comment on that.

GENERAL HILLMAN: I think the answer to the previous question partially answers this. The idea is to get the individual back to duty as soon as he is in physical condition to resume his duties, and naturally, if an organization is alerted for overseas and actually leaving, it would seem that it would be only reasonable to let certain cases, especially key personnel, join their units even though they were not 100 per cent reconditioned; that is, if the prognosis is such that you could expect them to be able to function in a short time. In other words, the Medical Department should do everything it can to use common sense and judgment in such cases.

MAJOR PATRICK: Thank you, General Hillman. The next question is, "Are not the problems of station hospital convalescents quite distinct and different from those of a general hospital?" We will ask General Willis to comment on that.

GENERAL WILLIS: Certainly they are distinct, but no different. There is only one aim in the Reconditioning Program for both station and general hospitals, and that is to get the patient to duty in the best physical condition possible in the shortest length of time, whether in station hospitals, regional hospitals or general hospitals. We have but one aim! All shoot at that!

MAJOR PATRICK: Thank you, General Willis. The next question is, "If officers properly prepared by attending OPE school are available and serving with the Reconditioning Section, can they be assigned, it being assumed that they are members of MDRP attached to the installation?" We will ask Major Esslinger to comment on this.

MAJOR ESSLINGER: If it is assumed that by OPE is meant the physical reconditioning course at Lexington, they may be assigned if you request them and have authorization in your T/O to make such a request. All members of the MDRP belong to the military personnel of the SGO. If they should be on temporary duty at your station, and you decide you want them, if you make your request through channels, it will come to military personnel in the SGO. It will be referred to us, and we in almost all cases will give approval.

MAJOR PATRICK: Thank you, Major Esslinger. The next question is, "Will occupational therapists be assigned to echelons lower than the general hospital? What effort, if any, is being made to train negroes as occupational therapists?"

MAJOR BARTON: Yes, it is planned to extend Occupational Therapy to the regional hospital as the next echelon to receive consideration. It would have been expanded before now had there not been such a shortage in OT personnel. We are still about 100 below the figure we set for July 1, as the number needed for general hospitals. However, we have now a streamlined four months' course, which will graduate 200 students over and above the number that the regular schools of OT are providing us; so we anticipate that we will be able to extend OT to other echelons, and extend beyond that as soon as personnel can be secured. As to the second part of the question regarding training negroes; as occupational therapists, there is no distinction by race. If there is need for occupational therapists, colored, a request should be forwarded to the OT Branch of the Reconditioning Division, SGO. There may be such trained personnel available in the country.

MAJOR PATRICK: Thank you, Major Barton. The next question is, "Are teachers being assigned from Hospital Headquarters? Our level of education demands much instruction." We will ask Major Ivins to comment on that.

MAJOR IVINS: Teachers are available within the camp. This question comes from a Station Hospital. They are assigned either by the Commanding Officer of the hospital or of the camp. I would be glad to talk about this question much more fully with the officer who has asked it. It is recognized that many men in this particular camp and this particular hospital do need assistance. I would be glad to talk this over with the officer later.

MAJOR PATRICK: Thank you, Major Ivins. This question pertains to funds. "What are the limitations in using the Hospital Fund for securing equipment such as public address systems, athletic and gymnasium equipment, newspapers, and other publications?" We will ask General Hillman to comment on that.

GENERAL HILLMAN: So far as the Surgeon General's Office is concerned, it has been the policy to interpret liberally the regulations in regard to the expenditure of Hospital Funds. As you know, there has been a tendency to build up Hospital Funds, and it has been the desire of The Surgeon General to utilize these funds rather than to have them turned in. That policy will continue with the new regulations pertaining to Hospital Funds. Now, specifically as to public address systems, I cannot answer that question. I know that athletic and gymnasium equipment, newspapers and other publications all come within the range of things for which we spend Hospital Funds. I think, to summarize, we should simply say that it is intended the regulations pertaining to Hospital Funds be interpreted very liberally. Concerning anything as large as a public address system for your hospital, I think you should seek further information. At least, I don't feel quite qualified to answer it here.

MAJOR PATRICK: General Willis may have a comment on that. He has the next question regarding gifts. The question is, "Is there any objection to accepting a public address system from the Red Cross if they can find a chapter that will furnish it?"

GENERAL WILLIS: I know of no objection to accepting it. I don't think any hospital commander should go out and solicit gifts for his hospital. That isn't necessary and it isn't good taste. If they offer it, I see no objection to it. The Hospital Fund is provided for the benefit of patients and duty personnel, enlisted. So far as I know, within reason, if the public address system is to be used to

broadcast radio programs to patients in the hospital, it is certainly a legitimate expense provided you can get the necessary priorities to purchase it.

MAJOR PATRICK: Thank you General Hillman and General Willis. We come now to ASF Circular 73, which provides certain policies and authorized certain personnel regarding the Reconditioning Program. The question posed is, "ASF Circular 73 provides for personnel to assist in the technical aspects of reconditioning. No authorization has been found for obtaining the clerical personnel necessary to operate the program especially in view of the reports and records required by recent directives. From what source should this personnel be obtained?" We have asked Colonel Thorndike to comment on the whole problem of personnel.

COLONEL THORNDIKE: Concerning the problem of personnel, it will interest you all to know that ASF Director of Personnel has today issued allotments specifically for reconditioning in each Service Command, those allotments should be in your headquarters today. So the allotment is authorized under ASF Circular 73. Now as to clerical personnel, it would seem to me that civilians and soldier patients can both help you with the problem of clerical work. Patients in the advanced reconditioning section who have done clerical work can certainly carry on for an hour a day as part of their duties in that section. I think that answers the question. We have to use soldier patients. It is good for the and they will be glad to do it.

MAJOR PATRICK: The next question bears on personnel also. It is, "Will additional personnel be allotted to cover the requirements of a separate unit for the reconditioning of neuropsychiatric patients." We will ask Major Barton to comment on that.

MAJOR BARTON: The allotment for reconditioning of neuropsychiatric patients for the advanced reconditioning section will follow the allotment prescribed in ASF Circular 73. You will recall that for each 100 patients in the advanced reconditioning section, one officer and three enlisted men are provided, one of those enlisted men to be a physical reconditioning instructor. That leaves two other enlisted men who are free to be any kind of personnel. It is suggested that they bear MOS serial number 263, and be psychiatric social workers or psychology students, but that is optional. In the larger units that we are setting up, we are now sending those 263's we have located to handle that aspect of the program. In addition, we are proposing that civilian occupational therapists and reconditioning aides in OT (which is to be a new category) will shortly be approved to fill the needs for special occupational therapists and industrial therapists for the reconditioning of NP patients. Otherwise, you stay within the allotment of ASF Circular 73.

MAJOR PATRICK: The next question is, "To what extent, if any, should the reconditioning of very short term patients be conducted? Reference is made to patients passing through evacuation hospitals and debarkation hospitals." We will ask Colonel Thorndike to comment on that.

COLONEL THORNDIKE: Evacuation hospitals in the overseas theatre of course are not expected to have anything to do with reconditioning. The debarkation hospital in the zone of the interior will help at least to provide an orientation for the patients arriving off the boat. Experience has shown, however, that it does patients good, when they are a short time in the hospital even for a head cold, to get into a uniform and enter the advanced reconditioning section for as short a time as two days. As short a time as that does them good. As far as an extensive program for debarkation hospitals is concerned, we do not intend to go into that.

MAJOR PATRICK: The next questions have already been answered, or at least partially. The questions are, "Are enlisted personnel assigned to reconditioning over and above the T/O of the hospital?" ASF Circular

73, as you know, authorized certain personnel and it was implied, if not directly stated, that that personnel would be in addition to the regular hospital personnel, but since personnel is being cut considerably, it has never been totally clarified. According to Colonel Thorndike's remarks it will be definitely stated. The second question is along the same lines, except that it refers to grades for enlisted personnel.

The next question is, "Can patient officers assume command functions with disciplinary action, except making and breaking of non-coms of a reconditioning company?" We will ask General Willis to comment on that question.

GENERAL WILLIS: If the commanding officer puts a patient officer on duty in command of a company, he must invest him with authority to demand discipline. I think that is a question that you have to use a lot of common sense about. I see no reason why an officer cannot exercise that authority while he is in command of a company, even though he is on patient status. That is the only answer I can give you.

MAJOR PATRICK: The next question is one pertaining to the monthly report due to the Ninth Service Command. As you know, that requires certain information regarding admissions, classification, categories, etc. We will ask Colonel Loutzenheiser to comment on that.

COLONEL LOUTZENHEISER: This is in regard to re-hospitalization, the term that was used in our monthly report. Re-hospitalization in that report refers only to the re-hospitalization of trainees who are in the advanced reconditioning section. It does not refer to patients who have been trainees and discharged to duty to nearby stations, and then who are possibly returned to your hospital. It just refers to those who have been sent to the reconditioning section or center, and because of their disability have been unable to carry on the program and have of necessity been forced back into the hospital. The next question is, "Will this extensive reconditioning program make it possible to commission enlisted men who are college graduates in physical education, and who have had experience in civil life?" This is not an officers' procurement program, and there is no provision whereby any man who may be qualified for commission shall be given one. The answer to that is "no" at present.

The next question I will ask General Willis to comment on. It is, "As far as personnel and equipment are concerned, what will be the status of the regional station hospital in the Reconditioning Program?"

GENERAL WILLIS: The regional station hospitals have not been designated as yet. They have been talked about, yes, but there has been nothing written on them. No policies have been announced except that a regional station hospital is to all intents and purposes a general hospital for the treatment of all classes of cases except overseas. The reason for their establishment is to lessen the load on the named general hospitals to which we transfer overseas patients. That is the only difference between them. In every other respect they are the same. They furnish general hospital treatment for Zone of the Interior patients, the named general hospitals being reserved for the overseas patients and those patients from both the Zone of the Interior and overseas, who require specialized surgery such as vascular surgery, neurosurgery, plastic surgery and things of that kind.

MAJOR PATRICK: I will ask General Willis to comment on the next question also.

GENERAL WILLIS: "Will the Reconditioning Section of a regional station hospital have the same organization as a general hospital, or will the Reconditioning Section remain on the basis prescribed for station hospitals?" As I stated a moment ago, the regional station hospitals are to be the same as general hospitals; I should think their reconditioning would be the same. Is that correct, General Hillman?

Colonel Thorndike agrees with me, anyway, so I would say that the Reconditioning Program for the regional station hospitals is on the same basis for the general hospitals.

MAJOR PATRICK: We got a little shy of copies of the questions. General Willis did not get the last question until just a moment ago. There is one other page of questions, and we will go through these rather rapidly. Then, if you have questions from the floor the panel will be glad to answer them for you. The next question is, "Orders require certain statements as to limitations. An enlisted man has to have a copy of orders with him, and therefore knows his limited assignment." That has reference to the paper which I read yesterday. The Surgeon General's letter that I quoted states definitely that the man is not to be informed of his specific future assignment. Now, the orders don't necessarily carry the specific assignment of the man. The orders should carry only the fact that the enlisted man or officer is a battle casualty and qualified for limited duty. Only rarely do orders carry the SSN in a transfer.

The next question is on personnel. "Has any progress been made in authorizations at the hospital level?" I believe Colonel Thorndike has already commented on that. Do you wish to go further, Colonel Thorndike? Colonel Thorndike has something further to say.

COLONEL THORNDIKE: You may recall that the last paragraph of ASF Circular 73, made out in March, requested you to submit (at least the Service Commands to submit) allotments they would require for reconditioning. Now as I stated earlier, those allotments have been issued and they are now available. Hospital commanders had better look over their original request and put in another request for the balance if they haven't the reconditioning personnel desired.

MAJOR PATRICK: Since Colonel Thorndike comes up again, I will read his questions. "Should all Class I trainees be kept until they are able to complete a 15-mile hike? How close should we come to this? Should trainees from different units be kept different lengths of time? Should we keep a man from the paratroops longer than one from a less active unit?"

COLONEL THORNDIKE: It is not necessary to keep all Class I trainees until they are able to complete a 15-mile hike. We try to return them to their normal duties. A clerk of course need not be conditioned, but the combat soldier must be conditioned for the 15-mile hike. I think this answers the second question. The next question is, "Should trainees from different units be kept different lengths of time?" Yes. I believe that common sense and good medical judgment should direct you as to when the individual is conditioned to go back to his outfit.

MAJOR PATRICK: Thank you, Colonel Thorndike. The next question, "Will national publicity on early exercising of abdominal operatives constitute a sufficient defense for the conservative surgeon who is leery of public opinion and occasional bad results?" That was a quotation of Major Esslinger's, and I have asked General Hillman to comment on it.

GENERAL HILLMAN: I think that what has already been said on that subject pertaining to hernias pretty well answers this question. I think that Major Esslinger will be the first one to agree that in reconditioning, the tendency on the part of a few surgeons, especially on the part of Dr. Powers, to get patients out of bed and have them take physical exercise earlier after surgical operations, was not intended to be set forth as a policy of The Surgeon General's Office. I understand that that was just cited as a report made by an enthusiast in this direction, and we must recognize Dr. Powers as an enthusiast and as an individual in making his report. Surgical policy will not

ordinarily be determined by the report of an individual. If after a few years our Surgeon Generals are beginning to look favorably upon earlier activation of a patient following abdominal surgery, then we can say it is something we might all follow. I hope that answer explains the policy of The Surgeon General.

MAJOR PATRICK: Thank you General Hillman. Next question, "When patients are transferred to the Advanced Reconditioning Section, does the hospital still receive bed credit for them?" We will ask General Willis to comment on this.

GENERAL WILLIS: A patient on the Reconditioning Program is a patient in the general hospital or the hospital to which he is assigned. If you mean, does the sending hospital have a bed credit for him, the answer would be that they have a bed credit which this one patient is using. If you refer to the general hospital, the man is still carried as a patient.

MAJOR PATRICK: Thank you, General Willis. The next question has to do with rifles again. "Do you have appropriate places for rifles?" I don't know whether they are asking if the panel has an appropriate place, or "does one have an appropriate place for rifles." I will ask Major Barton to comment on that.

MAJOR BARTON: I am not sure I know what the person had in mind, but again, the provisions of ASF Circular 108 apply. The appropriate place is not in the hospital proper. They must be stored in some other place than the hospital.

MAJOR PATRICK: Thank you, Major Barton. The next question is on specific reconditioning. "Orientation time has been allocated to Federal and State Legislation pertaining to recent bills passed as aid measures for soldiers returning to civil life. The prime objective is to acquaint the soldier with the benefits to be derived, not a discussion as to any controversial aspects thereof. Little has been said so far relative to this subject. Are there any criticisms on this procedure?" We will ask Major Ivins to comment on this problem.

MAJOR IVINS: WD Circular 300 makes the conduct of the army orientation course mandatory and calls for one hour a week. Now within that hour, the content will pertain to six training standards. Anything outside of that must be given in another hour or another time.

MAJOR PATRICK: The next question is, "Should A & R Funds be expended for equipment used by patients and detachment? The installation is over a year old; how can we requisition from Kansas City Depot equipment in kind for reconditioning alone?" Major Esslinger will comment on these two questions.

MAJOR ESSLINGER: I presume by A & R Funds is meant the funds which are available to the Special Service Officer, also known as WEMA Fund. Those funds are not to be expended for patients in the Reconditioning Program. If the Special Service Officer should buy some equipment, particularly athletic and recreation equipment for the station complement, that equipment could be used by the patients in the Reconditioning Program and is being used in most places. The second question is in regard to whether or not we can requisition equipment in kind for reconditioning alone from the Kansas City Depot. I think not. I think that the Kansas City Warehouse has been set up for the Special Service Division alone, and they are the only group that can make requisition in kind at that locality.

Colonel Thorndike asked the question about gymnasium equipment. That is not handled at the present moment in the Kansas City Warehouse. It is being purchased locally, and will continue to be purchased locally. I am thinkimg of some heavier items of gymnasium equipment at the present time such as barbells, and these purchases

will be made from those sources.

In regard to the last question, "What is the responsibility of the Special Service Officer in a general hospital to the patients?" I thought Captain Hogenson answered that very well this morning. Essentially the job of a Special Service Officer is with the station complement, and with the off-duty recreation of patients whom he may assist in many ways. However, many of these Special Service Officers are well trained in physical education and in athletics, and we know of innumerable instances where under the supervision of the Recreation Officer they can give considerable assistance in that direction. I think Captain Hogenson might answer further any question in that regard.

MAJOR PATRICK: Captain Hogenson, do you wish to comment on that question?

CAPTAIN HOGENSON: Not on that, but on the one before in regard to athletic equipment for station complements. If you are running short of athletic equipment for them, the Ninth Service Command Special Service Division has a surplus of stock in almost all kinds of athletic equipment. We have two store houses at this time, one at Camp Haan and one at Camp White, and from these storehouses we can furnish you with additional equipment for your station complement. To obtain this equipment, you submit a requisition on Form QM 445, stating the need for it, and we will ship it to you. That is in addition to your Kansas City requisition.

MAJOR PATRICK: General Hillman, let us question the Captain further. Do you mean strictly for the station complement? I think the point is, are you distinguishing between a station or camp that has a hospital, and a general hospital which is a station within itself? That is, the duty personnel of a general hospital.

CAPTAIN HOGENSON: I mean those units which previously could requisition through the Kansas City Depot, but have used up their allotment, or the equipment is used up through fair wear and tear. We can put additional equipment to your use, if you ask for it.

MAJOR PATRICK: Thank you. We are glad to get that information, I am sure. That brings to an end the list of questions that are written down. I wonder, if you have some questions, if you would care to come up here and state them, or state them from your seats, I will try to repeat them for you. There are some other things, no doubt, on your mind.

COLONEL SMITH: This is not so much a question, but I would like to know what is being done with regard to Occupational Therapy Funds, and the policy about selling the items made for enough to keep a revolving fund, not necessarily at a profit, but to make it self-sustaining. I have always done that, but I was told the other day that it was taboo and that I couldn't do it.

MAJOR BARTON: SG Circular 203, 1943, states definitely that for occupational therapy projects made by the patients, where the raw material costs less than $5.00, there will be no charge made for the equipment. This policy is based on sound reasoning. In connection with this, our Government regards occupational therapy as treatment. We don't charge a man for ultra-violet treatment, or for physiotherapy treatments. You cannot charge a man for the benefit he obtains through the making of an article, and, therefore, you will not charge a man for an occupational therapy article. It is intended, if you have need for additional material and you do not have an allotment, that you can purchase it out of the Hospital Fund. The fund is intended for that purpose and for the benefit of the patients, and you may spend that money freely for that purpose. We do not seek to build up any additional funds for occupational therapy equipment. Does that answer your question?

COLONEL SMITH: Not exactly. I am familiar with all that. My occupational Therapy Aide brought this matter to my attention. She said that she found when they did not make a reasonable charge for it, often the men did not take as much interest in it. I do not mean the men not able to pay should be penalized by price for therapeutic benefits, but it would keep out the horde of patient officers, in particular, who like to come in there and make things. They are perfectly well and it gives them something to occupy their time. That runs into considerable expense, and I have found that in spite of promises made at conferences like this, sometimes when you get back to your home base it doesn't work out so well. I have been doing it ever since I have been in the Army. We have set up two sets of books from appropriated funds - that generally takes care of the $5.00 proposition you speak of. We have another fund started out by donations or just plain credit. When a man makes a rug, we will charge enough to cover the yarn with little or no profit. It is merely a replenishment needed to keep it going, and to keep out those who like to come in and tear up or use up the material but derive little or no benefit from it one way or another.

MAJOR BARTON: It seems to me it would be unwise to charge some patients and not others, and, therefore, from the standpoint of policy, we must say that occupational therapy is just that - therapy for the patients; and to say how much or how little constitutes therapy is a very difficult question to decide, so we simply make a flat administrative policy that they will not be charged for it.

COLONEL MC EVERS: Are the occupational therapy facilities, and arts and crafts facilities, available to civilian patients, such as Civil Service Employees and dependents of military personnel, and also are they available to the detachment and to civilian employees who are now replacing soldiers?

MAJOR PATRICK: The question is, "Are occupational therapy facilities available to civilian patients and to other people who are not normally soldiers?" I believe that is a question for General Willis.

GENERAL WILLIS: If the Government authorizes you to take a civilian patient in the hospital, the civilian or what-not is entitled to all the advantages of that hospital.

MAJOR KANE: I would like to ask a question regarding station hospitals where there is a rapid turn-over of patients. Where a patient is brought in for a short period of time, perhaps a matter of a few days, I would like to know whether or not the questionnaire from the Ninth Service Command in reference to the patient's education and questions of what his likes and dislikes are, comprising three or four pages, should be filled out on that type of patient. Colonel Thorndike answered that question in regard to reconditioning; that if a man is in the hospital for two or three days, he should be given one or two days' reconditioning before being sent back to his outfit. I have still a third question with reference to the same type of patient. Someone comes in with a fractured finger, and a cast or splint is put on his finger. Then the commanding officer is contacted. We will say that the man is a clerk in that unit, or a key man. Many times we have returned that man to his own unit without any reconditioning at all. He is already in condition, as far as that problem is concerned, and can carry on light duty, even with a cast on his finger. I would like to know if that is permissible.

GENERAL WILLIS: No one can stand on a platform and tell you how to administer your hospital. There is no such thing as "light duty". If you return that man to his company, with a cast on his finger, you've got to carry him in quarters. You can't carry him on light duty. You can tell the company commander, if you wish, what duties he can perform. Nevertheless, he is carried on your sick report, and you carry him in quarters until he is well and goes to duty. As for reconditioning a man with a broken finger, I think that is ridiculous. I think

it shows no sense at all. He isn't going to get out of condition because of a broken finger. Those cases have got to be settled right in your hospital, with the idea that we are going to return as many men to duty in the shortest possible time, in the best physical condition. Now let that be your motto and your aim--to send them to duty in the shortest possible time in the best physical condition.

MAJOR PATRICK: Regarding the first part of the question that you asked, that letter was merely a suggested list primarily written for general hospitals in order to get something reasonably uniform. You would be surprised at how many different kinds of ingenious devices we can all make regarding forms. I am particularly interested in the forms developed here at Hammond. There are certain number of records necessary. But it is General Willis' wish, I know, and it happens to be the wish of those of us who are working on the service, to keep these to the minimum; however, you do have to have some records. At the time it was issued, I thought the letter said it was tentative, for your criticism and review. Out of it, we hoped to get a response from all the hospitals, and get some kind of workable form that would be adaptable to all. We are merely interested in uniformity. We may never use the individual forms. If you all go out and make your independent forms, and they all look different, it may be that that would be the ultimate outcome. We know that in the case of the station hospital patient with the broken finger, we don't have to take that record on him.

QUESTION: Major Barton stated awhile ago that a list of weapons could be obtained by general hospitals. I would like to know what the authorization is for the procurement of that number of weapons.

MAJOR BARTON: Those in conference with The Surgeon General, on the basis of the number of requests that were received, agreed to the numbers on the list I read.

QUESTION: Have any of the requisitions for weapons actually been forwarded to the Service Command?

MAJOR BARTON: I don't know whether they have been actually forwarded or not. I know they are actually filling requisitions received by them every day, so they must have reached the Service Command.

MAJOR PATRICK: I know of a specific case of a requisition forwarded through our headquarters to Washington, with an indorsement back, stating the same information that Major Barton gave you. In number the authorization of course is the same as that back in ASF Circular 180, but the number of rifles or number of different kinds of arms that will be issued, was never stipulated. That was a problem that was finally determined and on the desk about 30 minutes before we left, in an indorsement by General Hillman back to your unit through our headquarters, stating these same figures. We will try to get out something immediately upon our return, directing you along that line.

QUESTION: May I ask an opinion of the Surgeon General's Office concerning POE and so-called exempted stations. We have been carrying on our program without any authority.

GENERAL HILLMAN: My thought is that this applies to all hospitals except AAF hospitals. They have a program of their own, which is recognized by The Surgeon General as adequate, and is not covered by ASF Circulars. I have heard a rumor here today that there is some directive from the Chief of Transportation to the effect that reconditioning units will not be set up in debarkation hospitals, but I know nothing about that myself. I would say in general that ASF Circular 73, plus the earlier circulars SGO 168, and earlier WD Circular back in February, 1943 (I have forgotten the number but it was issued 11 February 1943) would give you ample authorization for carrying on such reconditioning activities as are professionally indicated.

MAJOR PATRICK: Are there any other questions that you have on your mind?

COLONEL ALLEN: I haven't any question to ask, but if the officer who inquired about the public address system will see me later I will tell him about it, because we just put one in our hospital.

MAJOR PATRICK: General Willis would like to have you come up here and tell us about it. This is Colonel Allen of the Dibble General Hospital.

COLONEL ALLEN: I had no desire whatever to get myself in trouble, and just wanted to answer a personal question, but I have just spent five months going through this whole performance at Dibble General Hospital. We are installing a head phone at the head of every bed, and we are also installing a public address system covering all the buildings, which may be switched on and off so you won't annoy patients who are really sick. The procedure is: First of all, of course, you get the money which you have in your Hospital Fund. You then submit your authorization which goes through and is to be approved by the Commanding General of the Service Command, by the Chief Signal Officer, by the Chief of Special Service Division, and by The Surgeon General, and they will grant you the priorities. After going through all this, and if your contractor is still willing to do business after that length of time, you can go ahead.

MAJOR PATRICK: Thank you, Colonel Allen.

QUESTION: Is it contrary to reconditioning policy to discharge a man before completion of his reconditioning if his organization wants to give him a furlough, specifically in the instance of a man with a simple hernia?

GENERAL HILLMAN: We do not feel that a furlough answers the problem of reconditioning. Reconditioning is different medically from a furlough, and a man with a hernia, we feel, can profit much more by reconditioning then by giving him a furlough.

MAJOR PATRICK: Any more questions? If not, we will turn the conference over to General Willis for closing. As you know, this is the last feature on the program. Thank you.

GENERAL WILLIS: General McCoach, have you any comments to make before we leave?

GENERAL McCOACH: No, I have nothing further to offer.

XXIV. SUMMARY AND CLOSING OF CONFERENCE

GENERAL WILLIS: Gentlemen, this has been a field day for the reconditioning people. They have answered all our problems, have spent our Hospital Fund, but they have had a good time. I wish at this time to express my personal thanks and the thanks of the Medical Department of the Service Command to General McCoach who has generously given his time to listen to this conference, on the spending of Hospital Funds, et cetera. We sincerely appreciate it and I can assure you all that General McCoach is behind the Medical Department in all of its work in this Command. When I reported for duty he said my one job was to keep him out of trouble. That is a pretty big order, but with your help that can be done. That is what we are here for. I wish to thank Colonel Poust for having us here. I know we have been a nuisance, and when he goes to bed tonight, he will say, "That is another shingle on the roof." I also wish to thank each one of the officers who have sent exhibits. I understand that this is the first conference of this kind in which they have had exhibits on reconditioning activities in the various hospitals. I think they have been highly beneficial. They have given thoughts to persons from other hospitals, and I am sure that there will be great benefit gained therefrom. Just a word more: those of you responsible for the exhibits will make such arrangements as you wish before you leave here as to their return. Some of them can be taken back with you, particularly Colonel McKie's who can take his back without causing any trouble by putting it in his hip pocket. Some of the pictures will have to be shipped back.

Is there any other question which anyone wants to bring up at this Reconditioning Conference? If not, we declare it adjourned.

ROSTER OF PERSONNEL ATTENDING RECONDITIONING CONFERENCE

MAJOR GENERAL

McCoach D., Jr.	USA	Ninth Service Command

BRIGADIER GENERAL

Hillman, C. C.	USA	Surgeon General's Office
Weed, F. W.	USA	Letterman General Hospital
Willis, J. M.	USA	Ninth Service Command

COLONEL

Allen, W. H.	MC	Dibble General Hospital
Balknap, Hobart D.	MC	Pasadena Station Hospital
Berle, Charles K.	MC	Barnes General Hospital
Blakeney, J. L.	CH	Ninth Service Command
Chamberlain, T. F.	MC	Camp White
Clark, A. P.	MC	Fort Lewis
Comfort, Charles W.	MC	Camp Adair
Curti, Ralph E.	MC	Camp Roberts
Flick, John B.	MC	Ninth Service Command
Gaines, A. R.	MC	McCaw General Hospital
Jones, A. B.	MC	Torney General Hospital
Keller, P. E.	MC	Ninth Service Command
Mason, Verne R.	MC	Ninth Service Command
Maynard, E. B.	MC	Fort Huachuca
McClinic, B. S.	MC	Sawtelle Station Hospital
McEvers, Albert E.	MC	Oakland Station Hospital
McKie, A. B.	MC	Baxter General Hospital
Miller, A. C.	MC	Birmingham General Hospital
Moore, Luther R.	MC	Camp Haan
Offutt, H. D.	MC	Hoff General Hospital
Pinger, Frank W.	MC	Camp San Luis Obispo
Sloat, J. I.	MC	Fort Ord
Smith, W. H.	MC	DeWitt General Hospital
Thorndike, A.	MC	Surgeon General's Office
Von Kessler, W. C.	MC	Camp Cooke
Woodruff, Charles W.	MC	Camp Beale

LIEUTENANT COLONEL

Berkor, Alfred B.	MC	Camp Beale
Briola, P. F.	MC	Camp Roberts
Davis, Philip B.	AUS	Torney General Hospital
Harmon, Merle S.	MC	Camp Callan
Leach, P. H.	MC	Camp Cooke
Loutzenheiser, John J.	MC	Ninth Service Command
Poole, Marshall W.	MC	Camp Adair
Prichard, J. L.	MC	Camp Kohler
Smith, Lauren H.	MC	Ninth Service Command
Vollert, Edward F.	MC	Camp Haan
White, M. D.	MC	Los Angeles P/E
Williams, S. W.	MC	Ninth Service Command

MAJOR

Barber, D.	MC	Fort Ord
Barton, Walter E.	MC	Surgeon General's Office
Bessesen, Daniel H.	MC	Barnes General Hospital
Briscoe, William	AUS	Surgeon General's Office
Esslinger, Arthur A.	AUS	Surgeon General's Office
Freeman, R. G.	MC	Hoff General Hospital
Ivins, George H.	AUS	Ninth Service Command
Johnson, P. T.	MC	Fort Huachuca
King, Robert W.	MC	Pasadena Station Hospital
Mishell, D. R.	MC	Birmingham General Hospital
Patrick, James R.	AGD	Ninth Service Command
Pike, M. Maurice	MC	Dibble General Hospital
Tennant, R. E.	MC	Fort Lewis

CAPTAIN

Barrett, Thomas F.	MC	Bishnell General Hospital
Bree, Donald W.	MC	Fort Lewis
Haigh, George F.	MC	Camp Beale
Hogensen, P. N.	AUS	Ninth Service Command
Johnson, Paul T.	MC	Fort Huachuca
Jones, Arthur C.	MC	Letterman General Hospital
Kogan, M.	MC	Camp White
Kootsey, Joseph S.	MC	Sawtelle Station Hospital
Mock, Joseph B.	MAC	Camp San Luis Obispo
Price, Carlton N.	MC	Oakland Station Hospital
Rudolph, H. B.	MC	Baxter General Hospital
Rust, Richard J.	MC	Camp Stoneman
Berholfo, J. E.	MC	Ninth Service Command

FIRST LIEUTENANT

Barger, George C.	MAC	Fort George Wright
Browker, Frank H.	MAC	Dibble General Hospital
Cohen, Howard T.	MAC	Camp Callan
Delahunt, John C.	MAC	Camp Kohler
Jacky, Lawrence L.	AUS	McCaw General Hospital
Johnson, Elmer G.	MAC	Camp Adair
Lockard, George C.	MAC	Oakland Station Hospital
Sutton, John T.	MAC	Torney General Hospital

SECOND LIEUTENANT

Borg, Kathryne A.	WAC	Ninth Service Command
Culler, J. J.	MAC	DeWitt General Hospital

CIVILIANS

Morena, Phyllis F.	American Red Cross
Steinmesch, H. A.	Ninth Service Command